California MEDICAL ASSOCIATION

NOTICES & REPORTS

Transactions of the House of Delegates

Los Angeles, April 27 to 30, 1958

The 1958 House of Delegates of the California Medical Association transacted a record business. It acted upon one proposed amendment to the Constitution which included four parts, on 17 proposed amendments to the By-Laws and on 72 resolutions.

This volume represents more than double the business coming before the House in 1957.

To handle the extra load, Doctor James C. Doyle, Speaker, named two additional reference committees, so that three committees handled new business and reported to the House. All resolutions were classified into the broad fields of public assistance, medical economics and general business, so that related items could be studied and resolved together. As a further means of assuring coverage of all items and eliminating overlapping, the members of the three reference committees on new business met before making their reports to the House of Delegates and reviewed the entire list of resolutions so that they could be properly assigned.

Of great help in the handling of such a volume of business was the cooperation of the county medical societies and their delegations in transmitting resolutions to the C.M.A. office in advance of the meeting. This enabled the office to prepare and place in the hands of the Delegates as they were seated about 75 per cent of the total business to come before them. While the House did not act favorably on a proposed By-Law amendment to require the advance presentation of all new business, it was obvious that the Delegates favored advance notice on the business they must consider and would cooperate in seeing that the members of the House are notified in advance of the work to come before them.

The following report of the transactions is an abridgement. A complete transcript of all sessions of the 1958 House of Delegates is on file in the Association office in San Francisco and available for the inspection of all members.

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At the first session of the House of Delegates of the California Medical Association, Sunday morning April 27, 1958, Speaker James C. Doyle named the following members to Reference Committees and their appointment was accepted by the House.

REFERENCE COMMITTEES

The Committee on Credentials: Finis G. Cooper, Huntington Park, chairman; Joseph G. Middleton, San Luis Obispo; George H. Houck, Palo Alto.

Reference Committee 1. Stanley R. Parkinson, Marysville, chairman; Howard E. Clark, Monterey; Fred E. Bradford, Los Angeles.

Reference Committee 2. Francis N. Hatch, Modesto, chairman; Donald M. Campbell, San Francisco; James J. Morrow, North Hollywood.

Reference Committee 3. Frederic Ewens, Man-

hattan Beach, chairman; John G. Morrison, San Leandro; Joseph W. Telford, San Diego.

Reference Committee 3A. Robb Smith, Orange Cove, chairman; Robert C. Combs, San Francisco; William F. Quinn, Los Angeles.

Reference Committee 3B. Burt Davis, Palo Alto, chairman; Robert L. Stern, Beverly Hills; Norman C. Fox, San Bruno.

Reference Committee 4. J. B. Price, Santa Ana, chairman; Roderick A. Ogden, Bakersfield; Robert B. Haining, Glendale.

Reference Committee on C.P.S. Business: Lewellyn Wilson, Anaheim, chairman; John F. Mayo, Lodi; Cedric C. Johnson, Santa Rosa.

The Constitutional Study Committee (to report Resolution 2 of the 1957 House of Delegates): Sam J. McClendon, San Diego, chairman; Robb Smith, Orange Cove; C. J. Attwood, Oakland; Matthew Hosmer, San Francisco; Carl Hadley, San Bernardino; Marden Alsberge, Glendale; James Moore, Ventura; Fred Olson, Fortuna; James Yant, Sacramento; Jay J. Crane, Los Angeles; Leslie Magoon, San Jose.

The Reorganization Committee (Resolution 24 introduced in the 1957 House of Delegates): Frederic Ewens, Manhattan Beach, chairman; Dwight Murray, Napa; John Cline, San Francisco; Lewis Cline, San Francisco; Dan Kilroy, Sacramento; John Rumsey, San Diego; James Feldmayer, Exeter.

The Adoptions Committee (on Resolution 41 introduced at the 1957 House of Delegates): Frances Holmes, Los Angeles, chairman; Russell Mapes, Beverly Hills; Joseph Telford, San Diego; Lee Fulton, Redding; Henry Tieche, Fresno; Jack Rovane, Sacramento; Agnes Plate, San Francisco.

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Mrs. Leonard D. Offield, President, Woman's Auxiliary to the California Medical Association, addressed the House of Delegates on the activities of that organization and urged greater use of the Auxiliary's forces and talents for medical public relations.

ADDRESS OF THE PRESIDENT

FRANK A. MACDONALD, *President*

Mr. Speaker, members of the House of Delegates, and guests:

As physicians, the greater portion of our daily thinking is concerned with the welfare of our patients, with scientific advances in medicine and with the multitude of duties associated with modern medical practice. As citizens, our minds are occupied with the problems of inflation, rising living costs, excessive taxes and spiraling wages. Consideration of these factors must of necessity occupy the greater portion of our daily thinking and seldom allow us an opportunity to consider carefully the serious problems which confront medicine.

So let's take a short recess from our daily activities and analyze some of these controversial problems. Scientifically, medicine has made dramatic progress for which the American public is wholeheartedly grateful. Our major difficulties lie in the fields of medical economics, legislation and in the political arena.

I. *Organizational and Administrative Problems*

For many years the C.M.A. has been growing faster than any other state medical association in this country and now boasts of over 16,000 members. With this rapid growth, mounting problems of an organizational and administrative nature have developed. The A.M.A., when confronted with similar problems last year, employed business experts to analyze its entire structure and subsequently obtained a blueprint for present and future improvement.

The Council in September of 1957, after careful investigation, instituted a similar survey in California. The same group of experts, Robert Heller & Associates of Cleveland, were employed and their report was completed in December of 1957. The Council has made many changes of an administrative nature in accordance with the California Heller Report. This report was also made available to the Constitution Study Committee appointed in conformity with Resolution 2 passed by this House in April of 1957. This special committee will report to the House of Delegates at this session and will make specific recommendations for organizational changes in the C.M.A.

In my opinion the California Heller Report has been of great assistance in high-lighting opportunities to improve the administrative and organizational structure of our Association. After careful consideration of this report by the House, the major problems in these fields should be settled satisfactorily for the present and a blueprint will be available as a guide for the future. I believe this entire situation was handled in an intelligent, efficient and business-like manner which should serve as a pattern for solving similar problems.

In conformity with these same business principles, a building was purchased in San Francisco in November of 1957 to permit future expansion of our rapidly growing central office. With this purchase, space requirements should prove satisfactory for many years.

II. *Communication*

With the rapid growth of an organization as large as the C.M.A. it is obvious that our lines of communication must be under constant scrutiny with a view toward making the transmission of information to individual physicians as perfect as is humanly possible. Recently a communications failure occurred during negotiations on the Public Assistance Program when information from the C.M.A. central office, after being forwarded to county medical societies, in some instances stopped at top county levels and was not transmitted to individual physicians.

Subsequently these methods of communications were improved but additional techniques remain to be utilized. For example, the basic function of county medical societies is changing rapidly since both specialty organizations and general practitioners now arrange scientific sessions at which subjects of special interest to their particular group are discussed. Hospital staff meetings likewise emphasize scientific problems as they relate specifically to hospitals. Consequently, county society meetings are frequently poorly attended, since subjects of widespread interest are limited. It would appear logical for county societies to gradually vary their programs so that more subjects of a medico-politico-economic nature are discussed. Debating these issues should generate ideas, stimulate interest, increase attendance and disseminate information in a manner which should be of important benefit to medicine. In addition, more data should be included in society bulletins of a medico-economic, medico-legal and political nature. Finally, the organizational sections of state and national journals should be followed by physicians with the same interest as the scientific portions.

The Heller Report suggested additional avenues for improving communications by arranging local meetings of C.M.A. alternates and delegates with District Councilors between the regular meetings of the House of Delegates. Conferences between these delegates and the District Councilor should serve as a "two-way street" by which local societies can become better informed of the C.M.A. activities and the Council in turn can keep more closely in touch with "grass root" opinions.

All of these suggestions should prove helpful in remedying the C.M.A. communications problem and additional methods may be devised by further observation and analysis of deficiencies.

III. *Medical Fees*

Bargaining with the state and federal governments and with various insurance carriers over medical fees is becoming increasingly important to medicine and, as would be expected, has aroused widespread criticism and controversy throughout the profession. Many physicians believe they are allowed no part in these deliberations in spite of the fact that their elected representatives do the actual bargaining. However, there may be some justification for this feeling among physicians that they have no voice at the bargaining table and, although there is no simple answer to this criticism, a remedy must be found.

The most recent attempt in California to arrive at a median fee for physicians occurred three years ago. Since that time many inflationary changes in the national economy have occurred and a new and more realistic survey of median fees in California is necessary immediately. Hereafter this survey should be conducted on a yearly basis in order to keep this data up-to-date. Unit values should be adjusted to the second edition of the Relative Value Study in accordance with the findings of these surveys which should represent the average fees charged by physicians in California.

In addition, at least one county society meeting each year should be devoted solely to a discussion of medico-economic problems at which the County Fee Schedule Committee should present the findings of the local yearly survey and should encourage discussion of these fees by individual physicians. The results of these deliberations should then be made available to the C.M.A. Medical Services Commission and should be given careful consideration in arriving at a median fee for the C.M.A.

The Council of the C.M.A. should set no medical fees in future except in an emergency, and then the fees should be of a temporary nature and should apply only until such time as they can be fully discussed in reference committees by the elected delegates from each society. You may be assured that the Council will gladly relinquish this task. Delegates should be given full opportunity to analyze these schedules and to officially vote their approval or disapproval at the House of Delegates meeting.

From a technical standpoint this procedure has been followed in general in the past, but opportunities for individual participation in fee determinations must now be stressed. Each physician should be encouraged to discuss fees individually and freely at his county society meeting. His elected representatives should present these views before the proper reference committee and later should make the final official decision. With this procedure no physician could justly feel that he had no voice in the establishment of his fees. This method may seem cumbersome and costly but no amount of time, effort or expense should be spared in solving this extremely important problem in intra-professional relations.

IV. *Professional Liability*

This problem is among the most important that faces medicine today. If some solution is not found shortly, scientific medical progress will be jeopardized. Many approaches to the professional liability problem have been attempted, some of which have proved valuable and others have failed. Psychological studies, which investigated attitudes in the causation of suits, were extremely interesting and for a time appeared to offer definite answers to this problem. However, the action program based on these psychological studies did not prove as valuable as anticipated and this approach does not now appear to be a major factor in the solution of the practical aspects of professional liability. Jury studies being conducted by the Medical Review and Advisory Board may clarify certain aspects of this complicated problem.

Claims prevention programs in hospitals through active tissue and record committees, through efficient supervision of hospital professional work and through education of the physician in avoiding the pitfalls in medical practice should assist in reducing the number of professional liability claims. These are the basic tools over which the profession has control. More positive use must be made of these corrective powers in order to lower professional liability actions and to raise the standards of medical care to the public. More recently the limited use of pre-trial examinations has proved beneficial in eliminating unreasonable and unjustifiable suits. Impartial panels of medical experts are now being selected in each county throughout the state to assure that competent medical testimony will be available to attorneys at all times.

Medicine must realize that the public is not concerned with the professional liability situation and that this problem must be settled by the profession itself. However, if every physician would become medico-legal minded and would learn to give careful consideration to the professional liability features of a case, along with its scientific aspects, the major portion of this problem would be solved. Postgraduate courses now being given in these subjects should prove helpful in attaining this aim.

V. *The Third Party Problem*

One of the most important and most highly controversial subjects in medicine today is the "third party" problem. This is a general term applied to any group which intervenes between a patient and his physician in rendering medical care. The "third party" usually consists of an insurance company, a prepaid group-practice organization, a union health and welfare plan or a governmental program. This subject has become so acute that five states introduced separate resolutions into the A.M.A. House of Delegates last June in an attempt to resolve differences of opinion involving medical care under union health and welfare funds derived from "fringe benefits."

Let me give you a few figures to help you decide for yourselves the importance of "third party" intervention in medical affairs. The annual report of the Health Insurance Council states that almost three and two-thirds billions of dollars were handled in health claims by third parties during 1956. In other words, doctors have been separated from their patients financially and hospitals have been forced to deal with intervening groups to the tune of that amount. "Third party" contracts handle ten million dollars in medical and hospital care daily in this country. In California it can be reasonably estimated that one million dollars per day is paid by third parties. It can be stated positively that these amounts will increase, not decrease.

Who controls these funds, how they are handled and how they affect the quality and quantity of medical care, are questions of vital concern to the medical profession. Blue Cross, Blue Shield, commercial carriers and certain state and governmental programs are considered less controversial than other plans which involve prepaid, closed-panel systems and which attempt to control medical practice. Medicine can logically expect increasing competition from prepaid group-practice organizations and union health and welfare plans. In an attempt to resolve differences of opinion between medicine, on the one hand, and labor and industry on the other, over "third party" relationships, the A.M.A. House of Delegates in June of 1957 adopted three basic principles covering the treatment of patients under the U.M.W.A.F. They intend to develop similar guides in the future for other closed-panel groups. These principles are:

1. Free choice of physician and hospital.
2. Fee-for-service.
3. Liaison from below upward.

These fundamental principles represent medicine's answer to competition from closed-panel systems and union health and welfare plans in general and will form the basis for future negotiations in national controversies involving these groups. Every physician should subscribe wholeheartedly to these principles which aim to maintain high standards in the practice of medicine.

Labor consultants made certain requests in California in April of 1957 which can be summarized briefly as follows: (1) Complete medical care, preferably on a service principle. (2) Certainty of coverage. (3) Fee schedules for competitive bidding

among insurance companies. (4) Low administrative costs (2 to 3 per cent). (5) Premiums which they consider reasonable.

The C.M.A. Council on July 13, 1957, answered the above requests and stated that they had no authority to dictate to members, that service plans such as CPS could be recommended only where inadequate income was involved, that relative value fee studies could be used, that public service committees should be consulted when disputes occurred and that discussions between labor and medicine should be continued.

Meanwhile, there are signs that California labor leaders are becoming more familiar with problems involving the medical care of their members and that California medical leaders are learning the value of continuing discussion and deliberation at state level. For these reasons both groups are approaching more closely although there still remains a considerable gap between them.

Both medicine and labor aspire to the identical time-honored goal, namely, "the best medical care at a price which every patient can afford to pay." However, medicine has continuously stressed quality in medical care, while some labor leaders have favored salaried "captive physicians" in the employ of prepaid closed-panel groups, chiefly because of their apparent low cost. The acceptance of major medical, co-insurance and deductible features in insurance contracts would rapidly narrow the gap of misunderstanding between labor and medicine. In fact, this disagreement and the refusal of labor leaders to use public service committees represent our major stumbling blocks at present.

Suits are on file in Colorado and Ohio to determine whether physicians or labor leaders will control medical society membership and the outcome of these court deliberations will help to decide medical standards for the future.

However, many enlightened consultants for labor health and welfare plans have accepted basic medical principles and, with continued discussion and experimentation, it is not unreasonable to hope that labor leaders themselves will gradually follow the advice of these consultants and make medical decisions on the basis of what is best for their members. In my opinion, continued negotiations with those consultants who control labor's health and welfare funds offer greater hope for a satisfactory settlement of this problem than prolonged discussion with less informed labor leaders. The C.M.A. Council is willing and desirous of cooperating along these lines in order to solve this extremely important and complex problem.

VI. *Government-Financed Medical Care*

Socialism may be defined briefly as the public collective ownership of land and capital and the public collective control over individuals, industries and professions. Veterans with service-connected disability, a large proportion of the dependents of military personnel and all public assistance and indigent cases have been socialized for medical care under this definition for many years. They look toward public collective management, *i.e.*, government, for this care; and government in making these groups, among many others, wards of the state has accepted this responsibility insofar as their medical needs are concerned. Three government-financed medical care plans are in effect (or are being considered) in California, namely, the Home Town care of Veterans Program, "Medicare" and the Public Assistance Plan. These specific groups formerly were treated medically by salaried physicians in Veterans' hospitals, by military personnel, by interns, residents and other physicians employed by the city, county or other political subdivisions and by volunteer physicians.

More recently government has made certain changes in the handling of the medical treatment of these dependents. Under federal law, private practitioners of medicine can now participate in the care of groups which formerly were treated by salaried physicians. Certain specific restrictions have been imposed by government on this medical care, including the type and amount of coverage, fees for professional services and the total money available for diagnosis and treatment. The government calls the tune, pays the bills and demands the usual excessive red tape, paperwork and regimentation.

Nevertheless, there are certain features in this new relationship with government which should be given careful consideration by medicine. For example, free choice of physician and fee-for-service are permitted, physicians individually and collectively can accept or reject these programs, medicine is allowed to select its own administrative agent in most cases and can bargain collectively for fees. These government-financed medical care plans for limited segments of the population have increased the total pool of individuals available for private practice and have transferred patients from public clinics and hospitals to the offices of private practitioners.

Although 19 million dollars previously had been allocated yearly in California for this program, the addition of 29 million dollars specifically earmarked for categorical medical care undoubtedly represents an extension of socialization in a program which in 1956 cost the state government approximately 375 million dollars. Furthermore, the lack of adequate funds to render complete medical care to these recipients necessitates excessive regimentation by the State Welfare Department.

For these and other reasons, many physicians consider that these programs represent a serious encroachment of socialization in medicine. Is this a valid conclusion? If so, then we discover several amazing paradoxes. The Veterans Administration looks with extreme disfavor on the Home Town Care of Veterans Program for obvious reasons and has managed through devious methods to eliminate this plan in all but eight states and Hawaii. Medicine, on the other hand, favors this program and the A.M.A. is attempting to extend its scope to additional states. Thus we have the strange paradox, if this veteran's care plan is truly socialistic, of seeing the government vigorously oppose socialism and the medical profession with equal vigor favor socialistic encroachment. Obviously this isn't reasonable. Opposition to "Medicare" by private practitioners will restore the care of military dependents to salaried physicians in service under government control. Lack of medical support for the Public Assistance Program will return these recipients to county clinics under salaried physicians or the State Welfare Department will be forced to employ physicians on salary in geriatric or pediatric clinics. For these reasons medicine can, if it so desires, exercise partial control over these programs.

However, there are many aspects of these plans with which many physicians disagree and others of which they heartily disapprove. In addition they dislike the excessive paperwork, the obviously inadequate fees, the governmental regimentation and the red tape and many of the annoying and frustrating characteristics of these plans. Nevertheless, I sincerely believe, from discussing these programs with many county medical societies and many individual physicians, that the chief opposition to these plans lies in the basic distrust of government by medical men and the sincere fear that medicine will eventually be socialized through these programs. Unquestionably there is justification for this concern.

However, let's consider these plans collectively as vehicles for the gradual extension of socialism in medicine by government. There can be no doubt but that government is gaining actuarial and statistical data from these plans which will prove extremely helpful to politicians in advancing future socialistic medical programs. Nevertheless, I sincerely doubt that medicine need fear socialization from these arrangements for definite, practical, economic and political reasons with which all physicians should be thoroughly familiar.

In order to understand this situation clearly it is necessary to take a quick look at the Social Security Act. This law became effective in 1936 and is divided into two portions: Title I, Old Age Security (O.A.S.) and Title II, Old Age and Survivors Insurance (O.A.S.I.). In my opinion medicines' main battle must be directed against O.A.S.I. rather than against O.A.S. for specific reasons which require further discussion.

First, let's consider O.A.S. Politicians realize that the American public does not want regimented medical care and that to bring it about they must resort to piecemeal, indirect and devious legislation. Taxpayers as a whole are forced to support charity welfare plans under O.A.S., and increases in the public assistance funds must come from the taxpayer's pocket. Increasing taxation is a technique which is obviously unpopular with the American taxpayer especially at the present time, consequently politicians prefer to avoid this method if possible.

On the other hand, under O.A.S.I. the employee pays a portion of the cost, the employer a similar amount; and, unknown to the American taxpayer, he underwrites the entire plan through hidden taxes. This so-called "insurance" scheme covers virtually every employee and employer in this country, together with the dependents of employees and excludes only physicians and certain governmental workers. Minor amendments to Title II of the Social Security Act (O.A.S.I.) by Congress at each session could gradually result in the socialization of medicine without the actual knowledge of or undue concern or criticism from the major portion of the American public. These amendments are readily added to law since the familiar argument is used that the individual is paying the cost himself and therefore is definitely entitled to all these benefits "by right."

Anyone who questions the above opinion can find a ready answer in the token resistance, consisting of one letter, offered by the A.M.A. against the Long Amendment to HR 7225 (the Public Assistance program under O.A.S.), in comparison with the extremely vigorous fight staged by the A.M.A. against the George Amendment to HR 7225 (cash disability at age 50 under O.A.S.I.) and in the active opposition now being organized by medicine against the Forand Bill (also under O.A.S.I.).

Every physician must obtain a clear-cut picture of these programs at present and must understand their significance to the practice of medicine in future. Basically these three federally-financed medical care plans are identical in principle and must be considered as one unit.

This House of Delegates finds itself on the horns of a dilemma and must decide either to oppose in principle the three federally-financed plans presently in effect in this state and draw the line at that level or to accept the basic philosophy of these programs and battle against further governmental encroachment and intervention by actively opposing future amendments to O.A.S.I. If this House of Dele-

gates should decide to oppose only one of these plans, for example, the Public Assistance Program, then it should, in order to be factual and consistent, make a careful distinction between opposition "in principle" and opposition due to "unnecessary regimentation, excessive paperwork, inadequate fees or political expediency." Furthermore, physicians must realize that they can hardly favor free choice of physicians and fee-for-service in principle for the general public and oppose free choice and fee-for-service for indigents.

This problem should not be decided on the basis of our present annoyances, frustrations and prejudices but must be considered from an unemotional, realistic, practical, long-range viewpoint in which the future relationship of this plan to medicine's battle against socialism is carefully weighed and critically evaluated.

VII. *Encroaching Socialism*

If medicine eventually becomes socialized, it will occur through increasing amendments to the Social Security Act, Title II, O.A.S.I. for reasons already outlined. Consequently, it is extremely important that medicine scrutinize any suggested amendments to this legislation.

The first and most important change in this Act, from a medical viewpoint, occurred with the passage of the George Amendment to HR 7225 in 1956 by two votes over the vigorous opposition of the medical profession. This law permits the payment of cash for total and permanent disability at age 60 rather than at age 65. In other words, physical disability has been singled out as a reason for the payment of social security allotments at the earlier date. At first glance this may not seem very important but on more careful analysis it will be found to represent the greatest legislative defeat suffered by medicine in our time. Adequate definition of the word "disability" is difficult and its interpretation can be easily changed by future legislative amendments. In addition, the word "permanent" can be readily changed to "partial or temporary" and the government can then demand proof of this disability by physical examination. At first, these examinations would be paid for by the patient and eventually by the government. From this brief outline the serious menace of the legislation becomes obvious.

Another attempt will be made by socializers this year to encroach still further upon the practice of medicine. The Forand Bill, HR 9497, introduced on July 24, 1957, is a proposed amendment to Title II, O.A.S.I. which would, among other changes, initiate hospital, nursing care and surgical payments for persons eligible for retirement or survivorship benefits under O.A.S.I.

This bill has the active endorsement of the CIO and AFL unions and the surgical portion of the proposal appears to be based on the experience of the UMWAF in five different states. This proposed legislation will be discussed in detail by the A.M.A. and C.M.A. legislative committees, so it will not be considered further except to outline an improvement in plans for opposing this type of legislation in California.

The Council, in agreement with recommendations of the Heller Report, has advised District Councilors and county society delegates and alternates to cooperate more closely and actively with the C.M.A. Legislative Committee and with county legislative committees in publicizing medicine's opposition to the proposed legislation and in bringing medicine's opinion to lay groups such as civic, church and educational associations, insurance, industrial and financial organizations and laborers, veterans and other taxpayers.

According to the reliable *Wall Street Journal,* "Over 100 lawmakers of both parties have dropped benefit-boosting bills into Congressional hoppers since last January." In our zeal to oppose the Forand Bill we must not lose sight of other amendments to O.A.S.I. in the medical field, which, if enacted into law, might permit government to advance further along the road toward socialization.

In Conclusion

The recent controversy over the Public Assistance Program has aroused physicians in this state to the vital importance of national and state legislation to medicine. At no time during the past thirty years has the profession in California been so stimulated politically except during the 1945 campaign when it opposed the then Governor Warren in his unsuccessful effort to force medicine into socialization. While the reasons for this recent controversy were unfortunate, there remains a silver lining to the cloud in the sudden awareness and active opposition on the part of the profession to further socialistic proposals by government.

In discussions with county medical societies during the past two years, I have endeavored to stress those principles which must be emphasized by physicians individually if medicine hopes to continue as a reasonably independent profession. These responsibilities underlie many of our major problems and bear repetition.

1. It is becoming more evident daily in the present political struggle for power between labor, industry and government that medicine is being "caught in the middle" and can survive, as we know it, only if we are a highly organized group. The medical profession, according to the politician, is so small numerically that we are unable to exercise

important power at the ballot box. Therefore, physicians must demonstrate to the public both by precept and by education the benefits derived from freedom in the practice of medicine. We must decide what is best for those we serve and then follow a specific course irrespective of all obstacles. We must use the influence of this group to determine the social and economic conditions under which our services are rendered.

2. Since medicine is rapidly being forced into the world of commerce, we must accept the bargaining tools of trade and learn to use them intelligently. We must cooperate fully within the profession in order to bargain successfully and to assist in establishing those principles for which we stand. What is good for the individual physician is not necessarily good for medicine; whereas what is good for medicine is always good for the individual physician. It is essential that we assume these responsibilities in order to render the finest medical care to the public in the present rapidly changing social and economic climate.

3. Medicine, if it is to protect the public, must continue to insist on its two great fundamental principles, namely, fee-for-service and free choice of physician and hospital. These are the basic principles which have made American medicine great.

While we as physicians are confronted with grave problems and vast responsibilities, we are also presented with broad opportunities and a great challenge. The advancement of medicine as a science will depend to a great extent upon how well we meet this challenge. (Applause.)

SPEAKER DOYLE: Thank you, Dr. MacDonald.

PRESENTATION OF FIFTY-YEAR AWARDS

Awards of pins commemorating 50 years of membership in the California Medical Association were made to the following physicians:

Dr. William P. Byron, Lemoore, Kings County.

Dr. Edith E. Johnson, Palo Alto, Santa Clara County.

Dr. A. W. Connor, San Jose, Santa Clara County.

STUDENT A.M.A. REPRESENTATIVES

The following representatives from California medical schools to the Student American Medical Association were introduced:

From the University of California: Henry Ralston, Jr., and Thomas Moyers.

From Stanford University School of Medicine: Wilmer Allen and Charles Hewl.

From the College of Medical Evangelists: Eugene Shakespeare and Fritz Westerhout.

From the University of California at Los Angeles: Carl Younger, national vice-president, Student American Medical Association; Harold Allen and E. Conway Stratford, Jr.

From the University of Southern California: Joseph Krofcheck and Richard Goode.

SUPPLEMENTAL REPORTS

The Speaker called for supplemental reports, beyond those made by various officers and committee chairmen in the Pre-Convention Bulletin, and the following reports were given:

REPORT OF LEGAL COUNSEL

MR. HOWARD HASSARD

Mr. Speaker and members of the House of Delegates:

This supplemental report is caused by the time lapse between preparation of our written report in January and several major issues of medical policy that have come to the fore since the first of the year. This report will be in the nature of a summation of the legal position of the profession in relation to economic as distinguished from professional problems in medicine.

In the immediate past these specific events have occurred:

1. A federal court has recently held that an Arkansas physician denied membership in his local county medical society could not invoke the Sherman Anti-Trust Act. There was no question of contract practice nor was a third party payment plan involved. The physician was a solo practitioner. The court held that the practice of medicine is neither trade nor commerce, and that if the denial of membership did interfere with the physician's practice such interference would not cast any burden on interstate commerce.

The case establishes that the practice of medicine *per se* is a profession, not a business, and hence is not within the ambit of the anti-trust laws.

2. At the same time two physicians in Colorado have commenced a $75,000 damage suit against a county medical society, claiming a restraint unlawful under the anti-trust laws, in that they were denied membership by the society on the ground that they participated in the United Mine Workers health plan. As you know, the United Mine Workers have a large fund for the payment of hospital costs and physicians' services incurred by miners and their families. At first, the Mine Workers fund permitted free choice of hospital and free choice of physician. In recent years, however, the fund has imposed re-

strictions on freedom of choice, and in various areas of the United States the medical profession has reacted aggressively as could be expected, in opposition to limiting patients' prerogatives. One weapon claimed to have been utilized to combat the Mine Workers fund has been society membership. *Life* magazine's issue of April 21, 1958, portrays the dispute and states: "Medical societies have begun denying membership and hospital privileges to U.M.W. doctors . . . doctors caught in between took their troubles to court."

While California lacks coal deposits and therefore is not directly concerned in the Mine Workers dispute, nevertheless all physicians throughout the United States are indirectly concerned, in that once again the issue is clearly raised as to what steps the profession may lawfully take to combat an economic force which medicine considers inimical to its economic interests.

3. In recent months our office has been questioned several times by physicians and medical groups as to whether organized medicine could improve its legal latitude in combatting economic encroachments, whether by government or private interests, through utilization of a labor union form of organization.

Frequently in recent months we have been asked to express an opinion as to the lawfulness of organized "non-participation" in a governmental program of medical care.

Due to these events I believe it timely, and I hope helpful in your deliberations, for me once again to review the status of medicine (regardless of how organized) under the anti-trust laws, and to define to the extent possible the boundaries of the playing field.

Basically, the anti-trust laws were enacted to protect free competition in all business activities. The motive was to protect the right of all Americans to improve their economic status without destruction by more powerfully entrenched competitive forces.

When medicine was practiced on a fee-for-service basis, and only the doctor and patient were involved in both the physician's services and the patient's obligation to pay therefor, there could be no destruction of competition arising from such relationship, and hence the physician and the anti-trust laws were strangers, and neither was concerned with the other.

However, when patients commenced to protect their economic interests by arranging for payment of the physician's fee through group action, an entirely different situation arose. The group arrangements for payment are an economic mechanism, not a professional matter; and such group arrangements, no matter what form they utilize, constitute businesses and as such are protected by the anti-trust laws against outside destruction. In this situation the practice of medicine *per se* is not the subject matter; the subject matter is the business of financing the costs of medical care.

Medicine first ran afoul of this fact in the early '40's when the American Medical Association and the Medical Society of the District of Columbia were proceeded against criminally by the United States Department of Justice. Parenthetically, I should emphasize that violation of the anti-trust laws is a crime as well as a wrong that can be the subject of a very expensive damage suit.

The A.M.A. case reached the United States Supreme Court. That court upheld a criminal conviction of the A.M.A. and the local medical society, because the court found that the A.M.A. by coercive tactics had attempted to destroy the business of a closed panel organization known as Group Health, Inc. The coercive methods used included ostracizing any physician who worked for Group Health, denying him county society membership, and closing hospital staff privileges to him. The Supreme Court said that it needn't decide whether the practice of medicine is subject to the anti-trust laws, because that was not the question involved. It said that the real question was whether the business of paying the costs of medical care was within the protection of the anti-trust laws; and the court's answer was Yes.

The court held—and this is now the law of the land—that a medical society to attain its economic objective may use reasoned persuasion but may not resort to coercion, either of its own members or others. The court said:

"If the District Society, acting only to protect its organization, regulate fair dealing amongst its members, and maintain and advance the standards of medical practice, adopted reasonable rules and measures to those ends, not calculated to restrain Group Health, there would be no guilt . . ."

May I emphasize, medicine may promote its economic view by reasoned persuasion, but if it resorts to coercion it may and has run counter to the nation's anti-trust laws.

The next medical anti-trust case to reach the United States Supreme Court was the other way 'round. It was an action brought by the United States Department of Justice against the Oregon State Medical Society to enjoin the Oregon Society from, among other things, continuing to sponsor Oregon Physicians' Service, the Blue Shield plan in Oregon, on terms different than were accorded commercial organizations. Here the Supreme Court said that medicine, far from interfering with economic competition, was itself engaging in such competition

and was doing so on a lawful and fair basis. The decision was in favor of the Oregon Society.

I should add that the evidence in the case established that the physicians had not engaged in coercive tactics against the contract practice associations operating in that state.

There have been several other anti-trust cases involving medicine, in Washington, Minnesota, Oklahoma and San Diego, but they merely serve to confirm the pattern established by the United States Supreme Court.

In the field of economics and in the business of financing the costs of medical care as the courts have ruled, medicine may reason and persuade but it may not resort to force, coercion, retaliation or duress.

This restriction on medicine's economic power has caused physicians to wonder from time to time whether medicine wouldn't be more effective if it were organized as a labor union. This query presupposes that labor unions are above the law. They are not. It is true that by statute and by court decision labor has won the legal right to engage in a strike against an employer for the purpose of improving wages and working conditions. True, any strike is a restraint on the business of the employer. But the right of labor to strike is not unlimited; labor's right is expressly confined to the employer-employee relationship and to the dual purposes of wages and working conditions. Whenever the strike weapon is used beyond these limited purposes, the courts have interfered and will interfere. In addition, when unions use their economic power outside of the authorized strike area to injure someone's business, they are liable under the anti-trust laws, and there are many cases in which unions have been found guilty of anti-trust violations.

The very pattern of the practice of medicine makes it impossible for medicine to fit into the collective bargaining strike zone of labor unions. By whom are physicians employed? If there is an employer, it is each and every patient. Against whom, then, could physicians strike? In all other areas the anti-trust laws would apply to medicine, whether organized as a medical society or a union.

Finally, I come to the question of governmental programs. With respect to the government, organized labor's right to strike is denied. Under the Taft-Hartley law it is unlawful for any government employee to participate in a strike against the government. Under the federal and California labor relations laws, public employees, whether federal, state or local, do not have any right to engage in collective bargaining. These restrictions probably had their origin in the disastrous railroad strikes that occurred immediately after World War I when the railroads were being operated by the United States governmental agencies. In any event, the right to strike against the government is, in a word, nonexistent.

This does not mean that in programs of medical care financed by the government individual physicians are forced to participate. Each physician may accept or not accept a government-financed patient as his own judgment and conscience dictates. But organized coercion to force physicians to act collectively for the purpose of destroying a lawfully established government medical program would, in my judgment, run afoul of the same public policy that denies to the employees of the government the right to strike against the government.

I think it is necessary to conclude that the union form of organization is unlikely to give medicine any wider legal latitude either in relation to private businesses or the government, than is now possessed by the profession. I suspect that in the field of economics medicine will, of necessity, have to live within the rule laid down by the United States Supreme Court, which I may oversimplify as follows: Persuasion—Yes; Coercion, No. (Applause.)

SUPPLEMENTAL REPORT OF THE COUNCIL

DR. DONALD D. LUM, *Chairman*

Mr. Speaker and members of the House of Delegates:

The *Annual Reports Bulletin* which you have before you contains the Report of the Council as prepared several months ago.

At this time the Council will report on additional items which have come before the Council since the original report was prepared or have been decided subsequently.

First is the matter of resolutions referred to the Council by the 1957 House of Delegates or indirectly so referred by the language of the resolution.

Three resolutions were referred directly to the Council by this House in 1957.

One of these, Resolution 8, Claude Calloway of San Francisco, author, urged that medically indigent patients who are beneficiaries of public welfare benefits be treated through private physicians and clinics associated with teaching institutions. The Council followed the intent of this resolution in its dealings with the State Department of Public Welfare under the new Public Welfare Assistance Law, legislation for which was passed shortly after the 1957 meeting of this House.

Resolution 38, Leon P. Fox of Santa Clara County, author, asked that nurse educators be impressed with the need of more bedside teaching. At the time this resolution was before the members of this House, legislation was progressing in Sacra-

mento which has subsequently established a shortened nurse training course for recognition for registration. This legislation is for an experimental period of five years, during which time there will be an opportunity to evaluate the efficacy of nurse training under a two-year program. The Council will follow the progress of this program and consider steps to be taken at any time in regard to it.

Resolution 40, J. P. Sampson of Los Angeles County, author, urged opposition to legislation which would lower the standards for foreign medical school graduates seeking to practice here. The Council has consistently opposed this type of legislation and has worked to maintain our high standards. A new organization, the National Council for Foreign Medical Graduates, has now been established by the American Medical Association, American Hospital Association and other recognized groups to provide a screening procedure for foreign medical school graduates. Time will be needed to determine the effectiveness of this screening procedure but it is obvious that it will give at least some indication of the qualifications of those who seek to come here from other countries and will eliminate those who are patently unfit to practice in California.

In addition to these resolutions sent directly to the Council, six other resolutions last year called for Council consideration.

Resolution 9, Donald M. Campbell of San Francisco, author, asked the development of a department and personnel in the Association to represent the C.M.A. before various bodies. The Council deferred decision on this matter until the Heller Report became available. Since that time the Association's staff has been augmented and a start made in the direction of the intent of this resolution.

Resolution 14, Burt L. Davis of Santa Clara County, author, asked consideration of legislation which would provide for the establishment of knowledge of the actual cost of injuries in court cases involving personal injuries. In view of the late date at which this resolution was adopted and the nearness of adjournment of the 1957 state legislative session, such legislation must necessarily be deferred until 1959. However, it is worthy of note that an interim committee of the State Assembly is currently inquiring into this field and has been furnished a copy of Doctor Davis' resolution for its consideration.

Resolution 10, Henry Gibbons of San Francisco, author, proposed that a staff be developed to implement the Committee on the Unlawful Practice of Medicine. Doctor Gibbons has appeared before the Council in support of this resolution and the subject remains open on the Council's calendar. However, it should be pointed out that there is a difference of opinion on this subject, based upon a consideration of the propriety of the Association's entering into activities which are currently the province of public law enforcement agencies.

Resolution 15, Grant Ellis of Alameda County, author, urged the establishment of a statewide hospital accreditation board for the promotion of advanced standards for our hospitals. Inasmuch as the Joint Commission for the Accreditation of Hospitals covers this field under standards which are applicable and are understood throughout the country, the Council did not feel that the establishment of a state board, to which the national organization would be considered in a secondary light, would represent much of value and might react unfavorably by debasing the national organization. Consequently, the Council has not taken any positive action on this proposal.

Resolution 25, Alf T. Haeren of San Mateo County, author, asked that opinion polls of the membership of the Association be taken on important matters. The Council is aware of the intent of this resolution and is prepared to utilize methods and facilities at its command when questions arise on such topics

Resolution 35, Clyde L. Boice of Santa Clara County, author, suggested that Council meetings be planned in various cities in the state so that local society officers might attend such meetings and better inform themselves on the deliberations of the Council. Two weeks ago the Council held its meeting in Sacramento, with officers of the county society present, and, while no schedule of such meetings can be announced at this time, the Council is aware of the benefits of such planning and will keep them in mind.

The Council also wishes to acquaint the members of this House of Delegates with the problem now faced in nominating candidates for election to the Board of Trustees of California Physicians' Service.

Under the C.P.S. By-Laws the Council is asked to nominate each year one candidate for each pending vacancy on the Board of Trustees and to place the names of these nominees in the hands of the members of this House 30 days in advance of the meeting. In addition, the Council is called upon to name three of its own members each year to serve a one-year term on this Board.

In view of the Constitutional Amendment which has been lying on the table for one year, and which will be voted upon later today, the composition of the Council during the coming year cannot be forecast at this time. It is most important that the three Trustees of C.P.S. named from the Council membership be carefully selected so that a direct liaison

between the C.P.S. Board of Trustees and the C.M.A. Council can be maintained. At the same time, it is equally important that the other trustees, who will serve terms of three years each, be most carefully selected for their ability to serve C.P.S. well.

Because of the uncertainty as to the composition of next year's Council, and because of the importance of these nominations, the Council has not yet placed any nominations in your hands. When this House of Delegates has taken action on the Constitutional Amendment now lying on the table, the Council will be in a position to make such nominations and will do so.

The Council wishes to nominate for election to honorary membership by this House of Delegates one of our members who has devoted herself to the cause of medicine far beyond the normal call of duty.

Doctor Edith Mary Meyers of Alameda County graduated from University of California Medical School in 1926 and entered the practice of pediatrics, a specialty in which she subsequently became a certified specialist. In 1948 she retired from the active practice of private medicine but continued to devote herself to good medical works.

For the past ten years she has maintained an active membership in her local, state and national medical associations, has paid full dues and has given freely of her time, her talents and her funds in the interest of good medical care. She has served throughout this period as head of the out-patient department of Children's Hospital of the East Bay, without recompense. She has served on the Council of the Alameda-Contra Costa Medical Association, has been chairman of that society's Child Welfare Committee, Credentials Committee and Advisory Board to Visiting Nurses, and a member of the Tuberculosis Committee.

Doctor Meyers has also, at her own expense, represented the society at the C.M.A. School Health Conferences and served on the Planning Committee for the School Health Conference held in Berkeley.

Honorary membership in the California Medical Association is seldom granted, and, on such occasions as it has, the recipient has always been a physician whose good deeds were outstanding. It is the sincere belief of the Council that Doctor Edith Mary Meyers qualifies for this honor and the Council respectfully nominates her for election by this House of Delegates to honorary membership.

The House of Delegates last year asked the Board of Trustees of California Physicians' Service and the Council to investigate the feasibility of providing members of California Physicians' Service with plastic identification cards. The Board of Trustees of C.P.S. did investigate this possibility and found the idea to be impractical because of an estimated cost of several hundred thousand dollars to provide the members with plastic identification cards and furnish physicians with equipment to handle such cards.

Finally, the Council has reviewed the various programs under which governmental units purchase medical services from physicians for various segments of the population. I am sure you have all been aware that during the past year the Council has been faced with numerous serious and very perplexing problems.

I would like, Mr. Speaker, to ask your permission to invite President-Elect West to discuss the thinking of the Council upon many of these matters.

SUPPLEMENTAL REPORT OF THE PRESIDENT-ELECT

DR. FRANCIS E. WEST

Mr. Speaker, members of the House of Delegates:

I have been instructed by the Council to address you concerning the problems of fees, service and indemnity type plans of prepaid medical insurance and the attitude of the Council toward these major issues. The tenor of this statement is the unanimous opinion of the Council; quite reasonably these are details which are open to much debate.

It is strongly felt that this House in the next few days must face certain issues and delineate policies to be followed. However, the Council, which sits in session at monthly intervals between the annual meetings of the House, would be derelict in its duty if the members failed to outline what has been the product of their experience during the past few years.

Perhaps if it were possible, we would be happy to renounce all third party fee arrangements and start over again, but we cannot. The Workmen's Compensation Act, Crippled Children's Program, Veterans Home Care Program, our own C.P.S., and "Medicare" make this as impracticable and untenable as it is unreasonable. Many of these programs operate with onerous rules and regulations, with fixed and frequently inadequate fees. And, in some instances, the question may arise whether there is even free choice of physician.

Since we cannot abrogate our position in relation to many of these plans, it becomes our responsibility to adjust our thinking and attempt to adopt general over-all policies which will be acceptable to the majority.

To aid in this undertaking, let us review some of our past actions.

In 1952 we had a C.P.S. Study Committee that faced these problems. After one and one-half years of diligent effort and some $50,000 expenditure, the committee made a definite recommendation to this

House. In 1954 Doctor Magoon read the report to you and it was received with standing acclamation. This committee recommended the Usual Fee Plan and indemnification as the basic type of medical insurance for general use.

A short time later, however, because of other problems, this House approved, as a temporary expedient, an increase in the income ceiling of C.P.S. to $6,000, which meant a service type insurance policy with a fixed (and, incidentally, low) fee schedule. Now these two actions seem to be fundamentally opposite fiscal policies and lead to confusion of both the public and the doctor.

The Council has not known for sure which of these actions—the Usual Fee Plan or the fixed fee service insurance plan—were to be followed. Meanwhile, there seemed to be instances where both plans were needed.

When the problem of "Medicare" came before the Council there were several men who on the basis of principle voted against accepting the program as offered, in that it was to be a service type plan with a fixed fee schedule administered by a government agency. However, "Medicare" was accepted and, in general, is being rather happily carried out by most doctors. Some of the complications, however, are now becoming apparent and we are beginning to harvest the results.

For instance, the Public Assistance Program is another government plan similar to "Medicare" but covering a different group of individuals, a somewhat different group of doctors, and with a slightly modified fee schedule; yet there are a tremendous amount of complaints.

These programs are part of one of the policies that medicine has been at least partially endorsing since 1939—that is, prepayment of premiums for the purchase of medical services, operated on a service type program with fixed fees.

At the present, we find ourselves at the end of a blind street. It seems we have now reached the point in logic—the conclusion—which inevitably follows once you accept a premise.

Every avenue we have followed for the past twenty or twenty-five years is converging to the point of putting a price on our service.

The report from the Public Relations Committee; the report from the Legislative Committee; the Medical Services Commission, and now the report from your Council—all arrive at this same conclusion: Medicine must face this problem of fees and the type of medical care insurance which we are all willing to recommend, to understand and abide by.

This problem of fees is intrinsic, because it is the product which becomes inevitable when one recommends prepaid medical care insurance. It makes little difference who handles the policy. When we endorse the principle of insurance as one method for the public to obtain their medical services, the people will then demand that we place a price on the service.

The only way to avoid discussing this problem of fees is to repudiate all previous actions and start anew. We on the Council do not feel that this can be done or that this House would want us to do so.

The Council feels we must face these issues squarely. We are aware the case is difficult and at times seems impossible, because it appears that by giving in we will ultimately be controlled. While the task is formidable, we must come to grips with the problem and set a realistic and reasonable policy that all of medicine, and the public, can understand and live by.

This House will have to face the fundamental issue of what we are going to do about fees.

The Council at this time would like to outline some thoughts for the benefit of your discussions.

We feel that probably there is no single complete answer to all aspects concerning fees. Confusion is great because we are speaking about many various government plans, the Workmen's Compensation Act and the general public, which includes both low income and adequate income groups.

For a logical approach, we would like to separate the problem into two component parts, one involving the adequate and other the inadequate income group. First, what can be done for substandard income groups, which would include: (1) Certain individuals who just do not have enough money to purchase adequate medical care; (2) certain employed groups with low incomes; and (3) certain governmental charges who are underprivileged.

It seems necessary to distinguish the group of governmental charges, as it would appear we are all going to be considered government charges under the Forand and similar bills. But there are certain governmental charges who are underprivileged. For years both medicine and the government have recognized these people and have given them medical care which probably is somewhat socialized. We prided ourselves on giving services not at reduced fees, but frequently for nothing. We have been proud to do this and we are sure most of us, if let alone, would continue to do so.

Then finally, there is a fourth category in the reduced income group—those who more recently have been taken care of to a great extent by the popular approach of the public agencies. These are people who are in need, with specific types of disease processes which are debilitating both physically and economically. This group could properly fall into

the realm of substandard income, or the medically indigent.

These four groups are entitled to consideration by medicine; whether it is the fellow who is just not making enough money, or whether it is the charitable attempt of the public agency. Or, in some instances, the benevolent taxpayer wishes those less fortunate be offered additional medical care and is willing to have certain amounts of his tax dollars appropriated for this care.

We feel in these instances that the intent on the part of either the agency, the taxpayer, or the individual, is good, and perhaps medicine should be willing to talk to these people about giving them a service type contract which would have a fixed fee schedule, and in certain instances, where the need is properly evaluated, and meets the proper definition of medical indigency or substandard income, to reduce our rate of pay.

The degree of reduction should depend on the degree of need of the individual. In some instances perhaps, this should be negotiated, or would, of necessity, be negotiated.

This type of coverage with fixed fee is service type insurance. Ideally, it should be offered through our agency, C.P.S., because it is the only vehicle in which the doctor has agreed to a fixed fee schedule. Any deviation from this vehicle becomes dangerous because we then tend to do what has probably been a fault in our approach during the past few years; we commit the doctors of the state to a fee by moral suasion. The Council recognizes this fact and wishes to be relieved of this problem.

In the case of the Public Assistance Program, approximately $30,000,000 annually is being spent in California on medical services. No matter what fee schedule is set, some doctors would have to accept it as a means of maintaining their practices. Therefore, we should have plans which are previously decided to be acceptable to all physicians of the group who are obliged to serve these plans. C.P.S. would be the logical organization to implement these programs.

We do not believe there are many physicians who have any real serious misgivings about how medicine will cooperate in taking care of people who are truly indigent or really have inadequate incomes.

The benevolent attitude of medicine toward the indigent, toward the unfortunate, has not changed. There is no cause for concern about charity care, since all of us have been donating this, as have our predecessors from time immemorial.

What is of concern is the fear of dictation in the matter, and the manner of the delivery of this charity or near-charity care.

In other words, if we are to give our services on this basis, we believe we have every right to say how our services shall be given.

The second group on which medicine must take a definite stand in regard to fee arrangements is the adequate or standard income group. This is by far the largest segment of our medical practice, and it is this group which presents the greatest problem.

The Council feels the earlier report of the C.P.S. Study Committee is still good and that there is probably no reason to have it changed or to develop a new Study Committee.

There is no question that when medicine suggests and offers prepaid health insurance as the way for individuals to take care of their health needs, it becomes a responsibility of medicine to offer some degree of certainty of coverage per premium dollar. It just isn't fair to do otherwise. The people concerned in this adequate income group are: (1) People insured by private insurance companies; (2) people under certain C.P.S. contracts; (3) people under labor contracts, and (4) government employees and others who are not indigent and who do have adequate incomes. This latter group is very important, as we feel there will be a large number of people in the future under government contracts who will not justify our setting either a fixed fee or reduced fee schedule.

In this group, medicine must meet its problems; but it must not be caught in the tangle of working down from its usual or modal fee. We cannot therefore properly offer a statewide service type contract with a fixed fee schedule.

We are aware that, in spite of this fact, certain doctors in certain areas will do so; some closed panel groups will be formed, and some doctors will sign up with certain insurance companies to serve some plans. That is an individual problem. But medicine, as an organization, should maintain its dignity and preserve that which is best for the patient and the profession and refuse to sanction such programs.

For this normal income group we would favor the annual establishment by this House of Delegates of what is found, by thorough and continuing investigation, to be the usual or modal fee for medicine throughout the state, fully realizing and adequately stating, that this is a median or modal fee and that there will be higher and lower fees charged in certain areas by certain doctors and under certain circumstances. This, then, means that the C.M.A., as a group, cannot endorse a statewide service type insurance program for adequate income groups.

For these groups, plans could be written against what are the modal fees throughout the state, with the insured recognizing that the final charges rep-

resent differences in particular areas and differences in particular doctors. In cases of fee disputes, however, as suggested in 1954, the usual or modal fee would be accepted as standard unless the physician had discussed his charges with the patient in advance.

This suggested statewide policy would not restrict any county society from accepting any contract which it might wish to arrange locally, such as a service type plan with a ceiling income limit. It is proper, important and right to maintain local autonomy.

At present this is being done in Stockton and in Long Beach. And I understand it is to be developed in other areas where service type plans with adequate fee arrangements are provided to preferred risks. If the local societies want to do this and agree to it, there is no reason for the state association to be concerned.

This has been a rather prolonged discussion, but your Council feels that we are at the crossroads and we in medicine must make major decisions. If we repudiate all that we have done in the past, we thereby deny the fact that prepaid medical insurance is proper. Then, to be consistent, we should withdraw from C.P.S., Veterans' Home Town Programs, "Medicare," Public Assistance and Cripppled Children's Care. Our alternative is to face the issue squarely and, as reasonable and intelligent members of society with a full realization of our responsibility to the public, our patients, resolve our present problems in a manner that befits the integrity of the profession and our proud record of humanitarian service! (Applause.)

REPORT OF C.P.S. BOARD OF TRUSTEES

DR. T. ERIC REYNOLDS, *President*

Mr. Speaker, members of the House, and guests:

This past year has been a busy one for California Physicians' Service, a year characterized by changes and challenges. This will be a short report in which I will attempt to put in capsule form the principal items which have concerned us and which I hope will interest you.

C.P.S. continues to have good physician support, as it should. There has not been a year since World War II in which the physician membership has failed to show an increase. Physician membership now stands at 13,767, a net gain of 109 over a year ago.

When C.P.S. was organized in 1939 by the C.M.A., one of the objectives set forth by its founders was that of providing a method by which the medical profession might provide medical care for special groups. In this way organized medicine has used C.P.S. when dealing with the government in the last ten or twelve years. Here is a "nutshell" review of such activities to date:

The first of such arrangements occurred in 1946 when the Veterans' Home Town Care Program was instituted. This program enabled a veteran with a service-connected disability to receive ambulatory care by a physician of his own choice in his own area, without traveling (sometimes for a long distance) to a government facility. C.P.S. was designated to administer this program for the physicians of California. This method of providing medical care has been helpful to, and popular with, veterans, largely because the program has been given the cooperation of the medical profession.

In December, 1956, the "Medicare" Program began here as a result of conferences between a committee from the C.M.A. and the Department of Defense. As a result, dependents of active duty servicemen can now receive in-hospital care by civilian physicians in nonmilitary hospitals. Once again C.P.S. was designated to act as the fiscal agent.

In each of these two instances the medical profession regarded these actions as forward steps by which further spread of the building of government hospitals was somewhat curbed. We believe that this is a sound medical principle and ultimately less expensive to taxpayers.

It was natural, therefore, that C.P.S. would again be called upon to act as fiscal agent by some counties when the Public Assistance Medical Care Program was instituted during this past year. Its functions are limited to receiving and processing bills and providing information, together with presenting complicated cases to county medical society review committees. These services are performed on a "no-profit, no-loss" basis as a public service. Thirty-five of the 58 county governments are availing themselves of this service. By an action of the Board of Trustees, no additional counties will be accepted for fiscal processing by C.P.S. unless specific request is made by both the county supervisors and the medical society of the county concerned. Functioning as a fiscal agent, C.P.S. can accumulate statistical data which we think will be of great value in the years to come. There is a distinct division of opinion regarding both the necessity for and the philosophy of contracting with the government to provide medical care for certain segments of the population. This is a matter for the considered judgment and decision of the House of Delegates. In any case, when the help of C.P.S. has been requested by medical organizations, it has been able to provide technical information and implementation.

Five years ago the Board of Trustees established a subsidiary corporation which is licensed to sell indemnity insurance. California Physicians' Insurance Corporation was incorporated in 1953. Approximately another year was required in securing approval from the California Insurance Department for specific policies. Some encouraging progress has been made, particularly in the last six months. This is a highly competitive field and when such coverage is required, buyers usually look to the commercial insurance industry for this product. So far the largest group which has purchased indemnity insurance from California Physicians' Insurance Corporation is the employees of Butte County, with approximately 400 persons.

Besides indemnity plans, this wholly owned C.P.S. subsidiary is offering two other plans. One is a major medical policy which becomes effective after the basic contract benefits are exhausted and after a deductible or "corridor" payment, usually set at $100, is made. The second offering by California Physicians' Insurance Corporation is a comprehensive deductible policy which pays, as an example, 80 per cent of the specified costs as soon as the contract holder has accumulated $100 of deductible medical expense. This type of major medical insurance is not based on any basic service coverage. The Relative Value list is being used in establishing fee schedules. It is fair to state that the subsidiary corporation, CPIC, has a somewhat brighter outlook than it has had heretofore.

Community rating versus experience rating continues to be a vexatious problem for all Blue Shield Plans. The natural tendency has been for commercial insurance carriers to select preferred risks, thereby leaving an important section of the people with the dilemma of having to pay more money for the same coverage, or accepting less coverage. It works like a cream separator. It is natural for any group to want the plan which offers the most benefits for their money. Larger groups are normally better risks and take advantage of the lower rates offered them. Smaller groups and individuals are adversely affected by this process. Whereas C.P.S. originally used the community rating concept which is basically the best for all people, it has been forced by competition to adopt experience rating for some, usually larger groups.

Very few commercial carriers offer any coverage for persons who are being retired. As the facts stand today, the Blue Shield and the Blue Cross plans are substantially the only programs through which it is possible for all subscribers to continue to receive protection when they retire due to age or leave work for other reasons. C.P.S. receives many letters of inquiry from people who are concerned that they might lose their protection when they need it most. Through the continued membership plan we can offer benefits which will not be cancelled because of age or heavy utilization of benefits. This feature has recently been of greater and greater interest to both management and labor and because of the spotlight which is now being turned on health insurance programs for the older age groups, it is a problem which will require the utmost in careful study and scrutiny by the medical profession, and particularly by its insurance "right arm."

Increasingly in recent times C.P.S. has emphasized the acquisition of individual members, as well as small groups, thereby offering protection to persons who might not otherwise be able to participate in prepaid medical care. Emphasis will continue in this area in the coming year.

During the year your Blue Shield Plan paid out more money for member benefits than ever before. It was necessary to dip into reserves in order to meet these obligations. Shortly after the annual meeting last year claims costs rose at an even faster rate than had been projected. Comparing our experience with that of other Blue Shield and Blue Cross plans as well as those of commercial carriers, we found that our situation was generally no different than that of other prepaid health plans throughout the country. Increased costs of hospitalization and greater utilization of benefits are the two main reasons for higher costs. The costs of hospital care reached an all-time high last year, and more C.P.S. members used their benefits, for one reason or another, than ever before. Even though California Physicians' Service is a nonprofit organization, it must remain solvent and have adequate reserves. Therefore, it was necessary to adjust dues. At the same time that contracts were converted we revised underwriting requirements by insisting on 75 per cent participation of individuals within groups in order to avoid self-selection against the carrier, which results in high loss ratios. Through these actions the stabilization reserves have been increased, so that once again they are in general agreement with the recommendations of the National Association of Insurance Commissioners.

The Board of Trustees has received many inquiries concerning a change in C.P.S. fee schedules. The last major change—there have been minor changes in the interim—took place when the B Schedule was adopted in 1955 to apply to the $6,000 income provision. On March 31, the last day of the fiscal year on which I am reporting, C.P.S. received word from the Los Angeles County Medical Association that the association had adopted a $5.00 coefficient based on the California relative fee list to apply to a new $7,200 income provision. Some of this new

type of insurance is already in force. It is impossible to predict whether other counties will also wish to adopt this schedule at this point. If this is done, however, and the plan is purchased by most C.P.S. groups, it will eliminate, to a large extent, the complaints concerning inequities in the present schedule.

Because there is constant confusion on one point, it might be well to repeat this fact: Fee schedules are set by a C.M.A. committee, not by the C.P.S. Board. The Board's responsibility is to make sure that new schedules or proposed changes in existing schedules are within the ability of C.P.S. to meet and remain financially sound.

There has been great enthusiasm this last year by some physicians as well as by the insurance industry over the growth of major medical and comprehensive deductible plans. The Board has undertaken considerable study and discussion of the long-term effects of such programs. We share the opinion of many leaders in the insurance industry that an objective examination is now necessary, based on experience to date. This is now being done by insurance companies, but needs to be done also by Blue Shield plans. Physicians have a great responsibility as well as an interest in the ultimate future of this kind of protection.

C.P.S. now has a continuing study committee. Some members of the committee are from within the Board. Others are physicians who are recognized as students of the problems of medical insurance. It is my hope and considered opinion that this committee will serve, along with the other excellent committees of the California Physicians' Service, to continue to acquire and digest the rapidly changing aspects of this problem and continue to advise the medical profession on the best course of action to pursue.

I should like to take this opportunity to thank the members of the Board of Trustees for their valued and loyal support and to thank the many physicians of California who have made representations to C.P.S. in a sincere, constructive and earnest effort to improve its performance. I should also like to thank the administrative staff of the organization for its excellent performance, oftentimes requiring time spent beyond the usual call of duty. I believe that they have well earned a commendation for a job well done.

In closing, I would like to repeat some remarks I made a year ago. Physicians are individualists by nature and training. That is how they function best and we would like to keep them so, insofar as possible. Blue Shield offers this opportunity within the framework of democratic processes. The old adage about free men governing themselves applies equally well to a free profession. Physicians should not be complacent worker-ants in a medical ant colony, whether doctor-sponsored or not. In my opinion, at least, no one has suggested a satisfactory basic substitute for the often maligned physician-patient relationship.

Blue Shield is organized medicine's device for reconciling new economic concepts with traditional, personalized medical care. If we continue to make it work, we may preserve the kind of medicine we would like for ourselves and our families. If we don't make it work, there are plenty of interested parties to take over. It is not a job done. It is a job only begun. It is a continuing challenge. It is a lifeline of free medicine. (Applause.)

REPORT OF THE CONSTITUTION STUDY COMMITTEE

DR. SAM J. MCCLENDON

Mr. Speaker, members of the House of Delegates and guests: The Constitution Study Committee came into existence as a result of Resolution 2 adopted by the 1957 House of Delegates.

This resolution, introduced by Doctor Joseph M. de los Reyes of Los Angeles, called upon the Speaker of the House of Delegates to name a committee which would include representatives of all existing Councilor Districts. It also assigned four specific areas of study to the committee. In compliance with this resolution, your Speaker named a committee of eleven members, one from each Councilor District. This committee was assisted by the Speaker and Vice-Speaker of the House of Delegates, who attended its meetings, by Mr. Hassard as legal counsel, and by John Hunton, executive secretary.

The committee received advance material in the form of maps showing Councilor Districts, statistics on individual county society membership and district membership, a survey of how other state medical associations handled matters similar to those assigned to the committee and a digest of the comments of numerous medical leaders in California, including many past presidents and other officers of this Association.

Two meetings of the entire committee were held. In addition, a four-man subcommittee was assigned the task of studying some of the items on the committee agenda, and this group held one meeting.

The four subjects assigned to this committee by the House of Delegates for study were (1) proportional representation on the Council of the Association for all Councilor Districts; (2) reevaluation of the necessity for continuing the so-called "gentlemen's agreement" on the rotation of elected officers of the association; (3) the desirability of reducing the size of the House of Delegates; and (4) the method of selecting Delegates and Alternates from

California to the House of Delegates of the American Medical Association.

These items will be treated individually in this report.

The members of this House of Delegates should bear in mind that additional studies of some or all of these matters have been made during the past year by others. A constitutional amendment introduced in the 1957 House of Delegates has been lying on the table for the past year and has been published several times in the official journal so that all members could study it. It addition, the Council of the Association retained a firm of management engineers to study the operations and the structure of the Association, including all four items which were assigned to this committee by your action a year ago.

This report is made with a knowledge of the proposals offered by the management engineers, Robert Heller & Associates, and includes a full consideration of the proposal for proportional representation made by the constitutional amendment which awaits your decision at this meeting.

The first item assigned to the committee was the consideration of proportional representation by Councilor Districts on the Council of the California Medical Association. As proposed in the constitutional amendment upon which you will vote later today, the theory of proportional representation would be approved; Councilor Districts 3 and 4, both embracing Los Angeles County, would be consolidated into one district; all other Councilor Districts would remain in their present areas, and Councilors-at-Large would be eliminated. The amendment would call for the election by the Councilor District delegates to this House of Delegates of one Councilor for each 1,000 active members in the district and would prohibit any Councilor District from electing at any time more than forty (40) per cent of the total Council membership.

The committee reviewed the present and the prospective size of the Council, and the areas from which its members would be drawn under the proposed constitutional amendment and agreed that, with one further amendment, it would support this proposal. The further amendment would add the words "or major fraction thereof" to the proposed representation of one Councilor for each 1,000 active members. If this further amendment were added and the present proposed amendment, as further amended, were adopted, the one change in the Council as proposed under the present amendment would be to add one additional Councilor from San Francisco and to make it possible for one additional Councilor to be added from Alameda-Contra Costa Counties within the next two or three years.

Since legal counsel has ruled that the further amendment proposed by the committee could not be introduced legally into this House of Delegates for action at this time, the committee intends to support and recommend adoption of the constitutional amendment which will be voted on later today. It will then, under the heading of New Business in this House, introduce its further amendment if last year's proposed amendment is affirmatively acted upon. If the amendment now lying on the table is not voted affirmatively today, the committee will then introduce under New Business a proposed constitutional amendment which will incorporate the proposals made last year, add the additional amendment voted by the committee and make a few technical additions in the interest of clarity. This amendment would then lie on the table until the 1959 session, at which time it would be acted upon.

The second item given to this committee for study was the consideration of removing any geographical consideration in the election of officers of the Association. Under the so-called "gentlemen's agreement" which has prevailed for a number of years, the House of Delegates has rather consistently elected a Speaker and a Vice-Speaker of the House of Delegates from the Los Angeles County area. At the same time, the Council, which elects its own officers, has regularly chosen its chairman and its Auditing Committee chairman, who may also be elected chairman of the Executive Committee, from among its members in the San Francisco Bay area.

Any such arrangement as this so-called "gentlemen's agreement" is obviously a matter of compromise and is not fixed by inclusion in the Constitution and By-Laws of the Association. In past years this type of agreement has been challenged in this House of Delegates by members from other areas of the state who have felt that these elective offices should be available to any worthy candidate, no matter from which county he came.

In considering this question the committee did not feel that a fixed and arbitrary basis for election of officers by geographical areas would be desirable. Rather, it was the consensus of the committee that these offices should be open for the candidacy of any qualified member, regardless of his geographical location.

Inasmuch as there is no fixed policy in this regard in the Constitution and By-Laws, there is nothing formal which this committee can suggest be amended. However, it is the considered opinion of the committee that the Speaker and Vice-Speaker of the House of Delegates should be elected without regard to their geographical location and that the Council, in selecting its own chairman and the chairman of the Auditing Committee, should he also be

named chairman of the Executive Committee, should follow the same principle. The committee believes that this principle, if followed, will contribute to a democratic administration of the Association's affairs and will make available to a greater number of members these official positions which carry with them prestige as well as responsibility.

On the question of the size of the House of Delegates, the committee considered arguments both pro and con. Those who favored retaining a large House of Delegates made the point that the more members there were in the House, the more there were to carry back to their constituents the details of what the House had accomplished. Those in favor of a smaller House pointed out that the present membership of 365 made this body unwieldy and, in fact, weighted the representation of the House in favor of some of the smallest societies, where a county society membership of possibly 12 members was entitled to two Delegates and two Alternates, or one-third of the entire society membership.

After considerable discussion, this question was resolved by the decision to recommend that each county society be represented in the House of Delegates by one Delegate and one Alternate for each one hundred (100) active members or major fraction thereof, with a minimum of one Delegate and one Alternate for each society. This would produce a House of Delegates of about 160 elected members, in contrast with 323 elected members at this time. With the addition of ex-officio members, including all members of the Council and the past presidents of the Association, a House of Delegates of 202 members would result. An amendment to the By-Laws to this effect will be placed before this House of Delegates.

The final item assigned to this committee was the method of selecting Delegates and Alternates to the American Medical Association. Discussion brought out the fact that the California delegation in the A.M.A. has been extremely influential in recent years and that every effort should be made to maintain that status.

It was the consensus of the committee that Delegates and Alternates to the A.M.A. represented the entire state and that the capacity of a member to give such representation was more important than the area from which he came. With this in mind, the committee agreed that nominations for Delegate and Alternate to the American Medical Association should be carefully considered before being placed before this House of Delegates. To assure the nominations of members whose qualifications would tend to fit them for such election, the committee voted to offer a By-Law amendment to provide for formation of a nominating committee to make nominations for each office of Delegate or Alternate to the A.M.A. This committee would consist of two members of this House of Delegates, two members of the Council and two of the present Delegates to the American Medical Association. The Speaker of this House would serve on the committee ex-officio, with authority to vote in case of a tie. Additional nominations would also be permitted from the floor. A By-Law amendment to accomplish this purpose will be before you for decision at this meeting.

As a final suggestion to this House of Delegates, the committee voted to recommend that a redistricting of the state be undertaken, to provide proper and proportional representation on the Council for each district. To accomplish this, the committee recommends that the Speaker of the House of Delegates name a committee to consider such redistricting in the coming year and to present its recommendations to the House at the 1959 Annual Session.

As chairman of the Constitution Study Committee, I wish to thank each of the members who gave thoughtful and serious consideration to the matters placed in the committee's hands. The committee members were, from the First District, your chairman; Carl Hadley from the Second District; Marden Alsberge and Jay J. Crane from the Third and Fourth Districts; James Moore from the Fifth, Robb Smith from the Sixth; Leslie B. Magoon from the Seventh; Matthew N. Hosmer from the Eighth; C. J. Attwood from the Ninth; Fred Olson from the Tenth and James Yant from the Eleventh District. (Applause).

REPORT OF COMMISSION ON PUBLIC POLICY

DR. DAN O. KILROY

Mr. Speaker, members of the House of Delegates:

My report will be a report of the Committee on Legislation, and will not cover the subject of public relations, which is one of the committees under the Commission on Public Policy.

Your Legislative Committee has been concerned, during the present year, with the activities of many committees of the California Legislature; with the current budget session of the Legislature and with the election of legislators and constitutional officers of this state. During this same time your Legislative Committee has attended meetings too numerous to mention with other committees of the California Medical Association, with various departments of the state and with Legislative Interim Committees.

Mr. Ben Read, executive secretary of the Public Health League, and Mr. Gene Salisbury, assistant executive secretary of the Public Health League, have attended all such meetings and in addition have

met with the various county societies and have attended meetings called in the various councilor districts for the purpose of explaining legislative problems as they affect medicine.

As you know, regular sessions of the Legislature are held in each odd numbered year and only during regular sessions may general legislative bills be introduced by the assemblymen and senators. In even numbered years, such as this year, the primary problem is a study of the state budget and only with the consent of the Governor may other legislative matters be introduced during the budget session.

One such item introduced and passed during this budget session is AB 6, the so-called diploma mill bill, which will be discussed in more detail later by Mr. Salisbury.

There are numerous budgetary items such as the budget of the Department of Public Health, the Department of Mental Health, the Board of Medical Examiners and others in which medicine has a very vital interest, and such budgetary items are watched with considerable care during the budget session.

It has been our observation that political medicine is becoming extremely complex and the effect of many apparently unrelated actions will in reality bring about important changes in the manner in which we may practice medicine in the future. For example, a judge in a small northern county renders a decision in relation to the staff rules of district hospitals—a decision of vital importance to the doctors of California. On the other side of the picture is the action of chiropractors in Riverside and San Bernardino counties in forming a chiropractors' union affiliated with the AFL-CIO. Why was such a union formed? The president of this chiropractors' union said, "Most of our patients are working people. By joining the AFL-CIO we can help with their union, health and welfare funds."

Medicine is cognizant of ever-increasing pressures from many directions to change the manner in which medicine is now practiced. We are told that no question is being raised as to the scientific portion of the practice of medicine: Most individuals and organizations concerned appear to accept the calibre of medical care as being generally excellent. Yet many of these same groups tell us that the economic distribution of medical care is unsatisfactory and that drastic changes will be required to produce a more efficient method of delivering medical services to the consumer.

Nelson Cruikshank, health insurance consultant for the AFL-CIO, has been quoted as saying: "We believe a union should try for a direct-service health plan, such as the Kaiser plan in California. If it can't get such a plan, the second-best sort of program is service coverage with an income ceiling such as Blue Shield offers. Last choice of all is an indemnity plan."

He further stated: "Our basic quarrel with the individual doctor is that he refuses to recognize he's a layman in economics. He may be even worse than a layman; he may be an illiterate. That's partly because his intensive training in medicine deprives him of the broader education a lot of other people get."

The manner in which medicine will be delivered and paid for in the future will become a matter of legislative concern unless medicine brings forth an acceptable answer to this problem. I need not point out that government at the local, the state and the federal level is interested, as a third party participant, in the economic distribution of medical care. Inasmuch as government represents the people it is obvious that the people have an interest in this problem. If medicine does not develop an equitable and acceptable answer to this economic problem the answer may be provided for medicine through legislation which might, in the end, be quite unpalatable.

The expressed attitudes of many legislators indicate some of the influences which will be brought to bear, in the future, upon your practice and mine. It appears that the further removed an elective official is from his constituents the more he appears, in the eyes of many, to lean toward measures of a socialistic nature. Many legislators appear to have a platform favoring motherhood, opposing sin and proposing the socialization of the practice of medicine. Perhaps the best known such measure is one introduced by Representative Aime J. Forand of Rhode Island (HR 9467). Senator Wayne Morse of Oregon recently jumped on this same bandwagon and, with a flourish of publicity, introduced a companion measure to the Forand Bill in the United States Senate. It is of interest to observe that the federal social planners, although they have not given up their plans to develop a social economy, have apparently become more patient and they appear content to approach their goal from many different directions. There is certainty that government will continue the present concept of paternalism toward the aged, the disabled and the deficient. There will be continuing legislative proposals, many of which will be medical in nature.

Medicine must now decide what attitude it will hold toward these various anticipated legislative proposals. Will we reject all pieces of legislation in the future in which government acts as a third party or will we instead establish a set of principles by which we can judge such future measures, recognizing that some of these proposals can be com-

patible with established basic principles of medical practice while others so violate those principles that they must merit the full opposition of that collective body known as medicine.

All future governmental medical plans, in which government has a third party interest, will undoubtedly arise in Washington, D. C. These will then be presented to the various states as grants-in-aid; and once this legislation has passed the federal level little can be done at the state level to turn back the tide of social legislation.

It thus becomes the responsibility of each physician, and through him the responsibility of each higher medical echelon to devise a set of principles by which such future legislation may be judged and to further decide whether medicine will or will not oppose any specific legislative proposal when it is measured against this rule of basic medical principles.

Medicine must further recognize that at the Washington level the voice of the doctor has been lost. We are repeatedly told, even by our legislative friends, that the American Medical Association, as a legislative organization, has become ineffective. This lack of ability to bring the problems of medicine to the attention of our senators and congressmen will cost us dearly in the future. A continuation of these same ineffective methods will produce further social medical legislation by the now unopposed do-gooders. Now is the time for decision and that decision must be made by the individual physicians.

The doctors of California have evidenced an increasing interest in legislation and legislative matters during this past year, and that increased interest has been both helpful and appreciated by your Legislative Committee. Without the interest and cooperation of each individual doctor your legislative program cannot hope to be successful. You cannot, by the passage of resolutions or the formation of committees, delegate this responsibility to others. Only through the individual and self-sacrificing efforts of each physician can we hope to continue an effective voice in Sacramento.

The chairmen of the legislative committees of the various county societies have been most helpful in carrying out your wishes. On April 19 and 20 of this year the legislative committees from the northern and southern portions of this state met for a discussion of the various candidates for Assembly, Senate and constitutional officer positions, and evaluation of the various candidates was done based upon the desires of the doctors in the various areas represented. From that meeting your committee received instructions so that we may, at the coming elections, carry out the grass roots intent of supporting your friends and leaving your enemies at home.

I wish to recognize at this time the members of the C.M.A. Legislative Committee, bringing them to your attention so that you may express your appreciation for the many hours of hard work which they have given in your behalf.

Dr. Justin Williams of San Francisco has represented the Bay Area for some long time on your Legislative Committee and has been of marked assistance to your committee and to the doctors of the Bay Area.

The other member of the C.M.A. Legislative Committee, Dr. J. Lafe Ludwig of Los Angeles, has been for many years a tireless worker for medicine. Dr. Ludwig, a member of the Legislative Committee of the California Medical Association is, as well, a member of the Legislative Committee of the American Medical Association.

Mr. Speaker, with your permission, I would like at this time to have Dr. Ludwig address this House of Delegates, speaking to you on national medical legislation.

DR. J. LAFE LUDWIG: Mr. Speaker, members of the House of Delegates of the California Medical Association: The Number One target of the A.M.A. legislation is the defeat of the Forand Bill and similar types of legislation. I use the latter part of that sentence advisedly, because there are some twelve bills introduced along this line, some even worse, such as the Proxmire Bill. A similar bill has been introduced by Congressman James Roosevelt of California.

You know in line with the letter you received from Dr. Palm, including the pamphlet on the Forand Bill, that the Joint Council to Improve the Health and Care of the Aged has been formed. It is represented by four organizations, the American Medical Association, the American Dental Association, the American Hospital Association and the American Association of Nursing Homes. There were practically no statistics available to enable us to come to a conclusion in arriving at a positive approach in opposing this bill.

Now, to the best of our knowledge, social security legislation is going to be heard by the House Ways and Means Committee approximately May 15. That will include the Forand Bill. One member of the House Ways and Means Committee, Congressman King of California, sitting as a member of that committee, should be forwarded any communications that you have relative to that, because it is our sincere feeling that if this bill comes out of committee with the recommendation for passage, and goes to the floor of the House, it will be passed. We have had numerous congressmen say that they have received innumerable letters from members of

the medical profession, and that instead of imploring them to vote against the bill should it come to the floor, and stating the reasons they should vote against it, the letters have been nasty letters, as they put it. So I would ask that if you do write your congressman, you give him logical reasons for opposing it rather than derogatory letters.

I would again call your attention to the fact that the A.M.A. *Washington Newsletter* is available for every member of the A.M.A. by writing to Washington, requesting that you be put on the mailing list. I checked with the Washington office about three months ago, and whereas we have some 15,000 members of the A.M.A. in California, there were only 281 interested enough to write for the letter. At last report, there are now over 900 in the last 90 days. As you know, you can keep current with the legislative problems in Washington by looking through your *Journal of the American Medical Association.*

One other thing: In line with this breakdown of communication that your president referred to this morning. Whereas in the past I have had a key man to be in touch with each one of the 30 congressmen in the state, about a month ago at the meeting of the Legislative Committee of the California Medical Association, we decided to stop this duplication of effort and from now on each legislative chairman of each county society unit will be hearing from me. So it will be up to the county legislative chairmen to break down the list as to what congressman or congressmen serve in their particular area.

I am not going to say anything about the Washington office. I heartily concur in everything that has been said. I believe it should even be carried further.

Dr. Dwight Murray, former chairman of the Legislative Committee of the C.M.A., a past president, and now legislative representative of the Council of the C.M.A., will now speak on national medical legislative problems.

DR. MURRAY: Mr. Speaker, Dr. MacDonald, Dr. West, members of the California Medical Association: I am certainly glad to be here, always glad to be present at any meeting of the California Medical Association.

A few days ago, the new general manager for the American Medical Association called me and asked me to bring to this group his greetings and best wishes for a successful meeting, and also the greetings of other officers and Board of Trustees of the American Medical Association.

You should know, as Dr. Cass said to you a few minutes ago, that it is of importance to California Medicine to know what is going on in the national scene. I want to say to you this, that the actions taken by this House of Delegates are not only of great importance to the people of California, but of great importance to the people of the United States. In organized medicine, California is looked upon as being one of the leaders; the California delegation is looked upon as the most important and strongest delegation in the House of Delegates of the American Medical Association. They rightfully do that too, because it is one of the largest and most powerful delegations. As you well know, this is the second largest delegation. At present New York has as large a delegation as ours. The number of delegates from New York varies according to the number of members they have, but we are fast overtaking them. It won't be long until we will have not only the most powerful but the greatest number of delegates in the American Medical Association House of Delegates.

I want to emphasize everything that has been said with respect to legislation. From the remarks that Dr. Kilroy made, you can understand how important legislation is, and it is becoming more and more important as time goes on. I remember a good many years ago arising to tell you how important it was in California. If it was important then, it is more important now. We realize that, and have realized it in A.M.A. for some years, that the legislative program in Washington was of the most importance. We also recognize that it was not what it should be. Just a year ago, now, we were considering the Heller Report having to do with the reorganization of the American Medical Association. The reorganization of the Washington office from the legislative point of view was put over until this year. In the past the Washington office has not been as forcible as it should be. Since it came into existence, we have had three different directors. Now, as you know, Dr. Alpin has resigned. He has left the Washington office. His resignation takes effect the first of May. In his place temporarily will be Dr. Kinnard. Dr. Kinnard has been with the American Medical Association office for some three years. He is a very capable man, but it is not expected that Dr. Kinnard will be the permanent director of the Washington office.

You heard from Lafe Ludwig, and you heard from Dr. Cass about the setup of the legislative program of the American Medical Association. The Legislative Committee is made up of men who are chosen from geographical areas. That Legislative Committee meets and goes through all of the bills that are important to medicine and tries to give its ideas not only to the Board of Trustees but to the profession generally, and it is the duty and function of men on this Legislative Committee to see that

information is presented to the members of the profession. That is a tremendous job. It is not toward what the Legislative Committee has done so much as what it is trying to do in the future that the reorganization is planned. Dr. Blasingame said this to me on the telephone: "Will you talk to the members of the California Medical Association and see what their ideas are with regard to this reorganization. There will be nothing done officially until after the Congress adjourns."

It would be a mistake to try to change now in the middle of a very intensive legislative program. Therefore, at the meeting of the A.M.A. in San Francisco in June this problem will be very thoroughly discussed. I understand that the California delegation to the A.M.A. has some very constructive suggestions to make about the Washington office. What changes are made will depend entirely, I think, upon the wishes and desires and the suggestions that may be put forth by the various delegations that will be in attendance at the meeting in San Francisco. I want to say to you that whatever is done, it will be done only after the most serious consideration, because we realize the importance of the things that Dr. Kilroy, Dr. Cass and Dr. Ludwig have said to you. It is important to have a very strong legislative organization in Washington, and we realize that if we do not have that, we are probably going to suffer more than we have in the past. By bills being passed that we do not like, we have suffered in the past.

Again, Mr. Speaker, I assure you of my appreciation for being here.

Thank you, Dr. Kilroy, for the opportunity of speaking to you once again. (Applause).

DR. KILROY: Mr. Speaker, Mr. Ben Read, executive secretary of the Public Health League, has again done his usual excellent job of representing medicine before the State Legislature and its various committees.

On behalf of the doctors of California, it is my privilege to express our appreciation to Ben for the undivided loyalty which he has given to the physicians of this state for these many years.

Mr. Vice-Speaker, with your permission, I would like to call on Mr. Read to present to this House of Delegates information pertaining to the coming elections in California.

MR. BEN READ: Mr. Speaker, members of the House of Delegates: As you all know, this is election year and, of course, as good citizens, we are all registered and are going to vote.

The primary election occurs June 3. At that time you will select candidates for United States Senator, 30 members of the House of Representatives, the Governor, the Attorney General and other constitutional officers. You will select twenty state senators and eighty assemblymen.

Some of medicine's good friends are retiring from the State Legislature, and others of your good friends face very tough opposition.

As Dr. Kilroy told you, the legislative chairmen of the county and district medical societies met with the Legislative Committee of the C.M.A. and representatives of the Public Health League, and information was given to them about candidates for the State Legislature, and these local chairmen were asked for their recommendations. This information has been passed along by these local chairmen to the members of your component groups.

Many of these contests will go into the final elections. It is not possible for them to carry it in the primary election as often as they used to, so in the fall we will have to do as in the past: Try to send our friends back and leave our enemies at home. (Applause.)

DR. KILROY: Mr. Gene Salisbury, assistant executive secretary of the Public Health League, a member of the team of Read and Salisbury, has again done his usual excellent work in representing the interests of medicine in Sacramento, for which we are all most grateful.

Mr. Speaker, with your permission, I would like to have Mr. Salisbury bring to the attention of this House of Delegates information pertaining to the various interim committees studying medical problems, and also information pertaining to the diploma mill bill.

MR. GENE SALISBURY: Thank you. Mr. Speaker, members of the House of Delegates: Dr. Kilroy has mentioned the diploma bill, Assembly Bill No. 6, that was placed on special call at the March session.

Now, this bill, which had our wholehearted support, is possibly one of the most beneficial bills that our organization has sponsored in a number of years. The bill as signed by the Governor and enacted into law provides for the prosecution (and carrying a felony conviction) of persons selling, bartering or purchasing a fake diploma.

Now, of equal importance are the regulatory provisions carried in the measure, which require the right of inspection under the State Department of Education, an annual inspection, and a reporting by all schools of their faculty, their students and their curriculum. This will be the first time in California's history that the State Department of Education has had the right and the obligation to inspect all schools of learning.

Now, because of our state's phenomenal growth, we find that legislation has become a twelve-month process, rather than a six-month or a one-month process in the even-numbered years. This is carried

on by the Interim Committees of both of the houses, the Assembly and the Senate. Indicative of this process is the fact that there are now in operation 84 Interim Committees. There are perhaps 20 out of those that are of immediate and direct importance to our profession. Perhaps the most important is the Senate Committee on the Investigation of Cancer Quackery. That committee under the chairmanship of Senator Jack Thompson of San Jose, has held two meetings. Its next meeting is scheduled for May 6, 7 and 8 in San Francisco. At the San Francisco meeting, we are going to be privileged to hear from Mr. Harry Hoxsey, Mr. Leo Hoffward and Mr. Fred J. Hart. With the assistance of the Cancer Commission, your position will be propounded by Ray Kaiser, M.D., of the National Cancer Institute, Charles Goldberg, M.D., from Dallas, a pathologist, and Harry Garland, M.D., of San Francisco, radiologist. We anticipate an extremely lively and interesting hearing.

We think, from our observations of the committee's progress, that we should be able to anticipate a bill for recommendations that may be most acceptable to medicine. (Applause.)

DR. KILROY: Before completing the report of your Legislative Committee, I wish to again commend our legal counsel, Mr. Howard Hassard, and Mr. Bob Huber for the advice and help they have given so many times to your Legislative Committee. This liaison between the legal department and the Legislative Committee is so close that Hap Hassard is regarded as a member of the Legislative Committee without whose help your committee would be most ineffective. These services to medicine are rarely noted by the individual doctor, yet we are all in the debt of Mr. Hassard and Mr. Huber.

The Public Relations Department, through Mr. Ed Clancy, has given invaluable assistance and advice to your committee, and for this we are indebted and grateful.

Mr. Vice-Speaker, members of the House of Delegates, this concludes the report of the Legislative Committee.

REPORT OF COMMITTEE ON PUBLIC RELATIONS

DR. SIDNEY J. SHIPMAN

Mr. Speaker, members of the House: I also would like to commend Mr. Clancy and his staff for the excellent work they did on the Public Relations this last year. Our full-time staff is an excellent group.

I would like to call your attention to the printed report of the Public Relations Committee, appearing on pages 78 and 79 of the March issue of CALIFORNIA MEDICINE.

In it the committee has stated that "the success or failure of the public relations effort for the entire profession, how its high ideals of dedication to service of the public are interpreted, can best be measured in the California press; not by an inventory conducted by ourselves!"

That inventory, as noted in the reprinted editorials, has, for the most part, been highly complimentary.

And here again at our Annual Session, the public relations of medicine, how we are meeting our obligations to the people of California, is on display in open convention— our actions to be reported in the press and our decisions the probable subjects for editorial comment.

The best public relations efforts are never spectacular, since they revolve around services the profession has long since determined the public has a right to expect.

During the past year these obligations have been met with increasing understanding and efficiency.

Outstanding, of course, is the continued effort of all county societies and branches to perfect emergency medical care under circumstances as varied as is California's population, geography and climate.

Next in importance is the increase in activity of our Public Service Committees, where misunderstandings between doctors and patients may be reviewed and adjudicated. Physicians everywhere, by their demonstrated integrity, have long since proved that these groups are not doctor-controlled, whitewash mechanisms.

One has only to attend a meeting of a County Public Service Committee to realize the determination of the profession to correct doctor-patient dissatisfaction found to be the fault of physicians. In this, of course, we are not entirely altruistic, because the results show that a misunderstanding that can be corrected within the Public Service Committee room never reaches the jury room of the court house.

In this field of the prevention of professional liability suits, your Public Relations Committee looks forward to cooperation with the Medical Review and Advisory Board.

Another dividend from active Public Service Committees is the furthering of the stability of the operation of voluntary insurance plans—major medical cost coverage being a case in point, where the prevention of abuses by either the patient or the physician is a prime requisite for growth of this comparatively new innovation in the prepayment field.

The many discussions of the operation of the controversial indigent care program have highlighted another of our basic public relations tenets,

to-wit: While a variety of resolutions are to be introduced on the subject; while there is disagreement on the operation of the plan, there is no deviation from our determination to care for these and other patients regardless of their inability to pay.

Reviewing these public relations accomplishments, as we have stated, is not spectacular.

What is spectacular is when one of us fails in his responsibility to the patient—to the profession!

That failure can be reflected upon the entire profession with such speed as to jeopardize a proud record of countless successful physician relationships.

That we've had but one minor breakdown during the past year is a credit to all. Particularly is it to the credit of the diligence and determination of county society officers and, in the larger areas, to the day-in and day-out "follow-through" on the part of the executive secretaries.

Your Public Relations Committee has had two successful meetings during the past year, at which we reviewed the operations of the Public Relations Department.

Because of the inter-relationships between Public Relations and Legislation, Dr. Dan O. Kilroy, chairman of the Commission on Public Policy, along with Mr. Ben H. Read and Mr. Gene Salisbury of the Public Health League, has attended these meetings.

Following the directives of this House, the Public Relations Committee has continued to work with students, residents and interns.

On March 30 of this year, in cooperation with the Los Angeles County Medical Association, we held the Fifth Annual Public Relations Conference for the Student A.M.A. members from USC, CME and UCLA.

On April 13 a similar meeting was held in cooperation with the San Francisco County Medical Society for the UC and Stanford students.

This program has been in operation a sufficient time to prove its effectiveness in that many of today's young physicians who are taking active parts in the affairs of their county societies received their first introduction to county and state functions at our early C.M.A.-sponsored Student A.M.A. meetings.

Newsletter, which is distributed each month to all C.M.A. members, members of the Auxiliary, medical students and all delegates from other states to A.M.A., has proved a valuable information medium. The committee received some personal satisfaction when the Medical Society of the State of Pennsylvania started an identical publication.

During the past year California physicians passed the four million mark in the distribution of pieces of public relations material to their patients. These C.M.A.-prepared messages telling of the physician's availability in case of an emergency, his explanation of fees and willingness to discuss them in advance of treatment, and his support of voluntary health insurance plans, together with the very popular Health Records, were submitted in competition to the American Public Relations Association. While the official announcements will not be made until May 2 at the Waldorf-Astoria, we are pleased to state that the California Medical Association will receive an Achievement Award when the judges submit their decisions.

During the year C.M.A.'s First Aid Charts were made available to all physicians. Orders have continued to come in from all areas, indicating physicians have found this is another valuable public relations tool to demonstrate interest in patients. The same goes for the Athletic Injury Charts. This C.M.A.-prepared chart is now on display in nearly every school in the state, and county societies have used it in connection with meetings with health educators and at athletic injury clinics.

Both charts have been widely copied throughout the nation.

This is again an election year. From the public relations standpoint, it is our hope that California physicians, working in close harmony with the Public Health League and County Legislative Committee chairmen will take an active interest in the support of candidates who understand our determination to preserve high standards of medical care.

The minutes of the February 8, 1958, meeting of the Council state:

"The Council shall establish policies relative to public relations and transfer such policies to a strong Committee on Public Relations which shall direct and supervise this activity."

Since the Council receives its directives from the House, we await your decisions. Once they are made, we have every confidence that your Public Relations Committee, acting with the continued fine support of the 40 component county societies, will carry them out to your complete satisfaction. (Applause.)

REPORT OF THE JUDICIAL COMMISSION

DR. DONALD A. CHARNOCK

Mr. Speaker, members of the House: The Judicial Commission with the aid of legal counsel is engaged in preparing a detailed statement on disciplinary procedures. This will be sent to each county society and will outline the steps to be followed in preparing disciplinary charges. The statement will outline the rights and privileges of members in preparing their defenses in disciplinary proceedings.

REPORT OF COMMITTEE ON REORGANIZATION

DR. FREDERIC EWENS

Mr. Speaker, members of the House: The resolution on Constitutional Amendment [No. 2] has been withdrawn. As to Resolution No. 24 that was presented to the House in 1957: The committee has considered the matter referred to it by the House of Delegates, and it is of the opinion that further time and study are required to arrive at a final conclusion.

It is therefore recommended that the committee be continued with the expectation that a formal report of its deliberations will be made at the next Annual Session of the House of Delegates.

RESOLUTIONS ADOPTED

Shown below are the resolutions adopted by the House of Delegates or referred to the Council or to committees of the Association. Where pertinent, the comments of the appropriate reference committee of the House of Delegates are appended.

PUBLIC ASSISTANCE MEDICAL CARE PROGRAM

Resolution No. 1.*

WHEREAS, The federal formula of permissive legislation to states on a dollar matching basis has created an apparently irresistible attraction to the majority of the states; and

WHEREAS, Resultant State Legislation (i.e. AB 679) appears to be founded more on the automatic appropriation of available funds than on such fundamental issues as the demonstrated need for such legislation; and

WHEREAS, There had indeed been no factual local demonstration of need for this program before the State Legislature; and

WHEREAS, Federal and state programs necessarily entail federal and state control in order to insure protection of the tax dollar with resultant loss of traditional local autonomy and responsibility to solve local problems, and

WHEREAS, AB 679 provides for and results in unreasonable and unnecessary dictatorial control of both patient and physician; and

WHEREAS, Any welfare medical program administered by national, state and county agencies with resultant multiplicity of controls results in heavy costs in the administration, and an increased tax burden; and

WHEREAS, The practice of medicine under AB 679 fails to maintain high ethical regard for all phases of medical care, violates privacy of patient and physician relationship, essentially abolishes patients self-respect and personal dignity, nullifies any effort to maintain family responsibility for care and fails to stimulate any honest effort on the part of the patient to carry as much as possible of his financial responsibility, and

WHEREAS, Economic problems concerning the provision of medical care for indigents and the elderly do exist which require the leadership and imagination of doctors both from humanitarian motivations and from the desire to maintain the private practice of medicine, and

WHEREAS, From time immemorial, physicians have cared for the indigent without thought of compensation and will always do so without government control or administration; therefore, be it

Resolved, That this House of Delegates go on record as rejecting the principles incorporated in AB 679 and that cooperation past and future in the care of the patient under this program in no way implies endorsement of O.A.S. and O.A.S.I.; and be it further

Resolved, That the House of Delegates of the California Medical Association instruct the Council to join with other interested groups in exerting maximal effort and full resources, and any other facilities to repeal Assembly Bill 679 and applicable Federal legislation; and be it further

Resolved, That recognizing that AB 679 is now law and recognizing the paramount obligation to protect the welfare of our patients, The House of Delegates urges that immediate steps be taken to improve the program and to eliminate existing defects in AB 679 and its administration, as follows:

1. Medical care programs be controlled and administered by the individual counties, with licensed physicians exercising through their organizations the degree of control over the appropriate agency commensurate with physician's responsibilities to the patient.

2. To expedite return of control to the county level, medical societies should cooperate fully with their local Welfare Board in administration of the program, in determining the needs of such a program and appraising the effectiveness of the screening of recipients and controlling any abuses of the program, and if possible, securing physician membership on the local Welfare Board.

*The resolution adopted was prepared by Reference Committee 3A as a substitute for twenty resolutions introduced on the same subject. These were originally numbered 1, 4, 10, 12, 13, 17, 21, 22, 24, 35, 36, 37, 38, 39, 55, 57, 65, 66, 69 and 72. The substitute resolution is shown here as No. 1 since that was the first of the series.

3. To accelerate return of control to the county level, various pilot programs such as the feasibility of the physician charging patients his usual fee without restriction, and other appropriate studies, at a local level, should be instituted without delay.

4. Removal of the prior authorization system to take place as soon as the present pilot program has developed information deemed adequate by the California Medical Association liaison committee.

5. That a uniform method of payment should be adopted, the most acceptable method of payment to be determined by a poll of California Medical Association membership.

6. That the officers, Council and Legislative Committee of the California Medical Association be instructed to urge the Governor to appoint one or more physicians to the State Board of Social Welfare.

ACTION: Adopted by House.

* * *

C.P.S. MEDICAL PERSONNEL

Resolution No. 2.
Author: Robert C. Combs.
Representing: San Francisco Medical Society.

WHEREAS, California Physicians' Service has in the past few years attempted to regulate the length of hospitalization of its subscribers; and

WHEREAS, The investigation of suspect cases has largely been conducted by *lay* personnel of California Physicians' Service; and

WHEREAS, Such personnel is not adequately trained to interpret medical reports and hospital records; and

WHEREAS, Decisions reached in this manner constitute an infringement on the practice of medicine, especially when the attending physician's judgment is questioned; and

WHEREAS, The physician is usually held responsible by the patient when all or a portion of the hospital bill is not paid by California Physicians' Service; and

WHEREAS, Other insurance companies in this field have rarely undertaken such police action in arbitrarily curtailing benefits anticipated by the patient and physician; and

WHEREAS, This type of solution to the problem of alleged unnecessary hospitalization has resulted in poor relationship between the patient and his physician, as well as between the physician and California Physicians' Service; and

WHEREAS, Most of these questionable cases could be easily resolved or clarified by a telephone conversation between the medical director of California Physicians' Service and the attending physician; now, therefore, be it

Resolved, That the California Medical Association House of Delegates request an immediate review of this practice by the California Physicians' Service Board of Trustees and suggest adequate medical personnel and more direct communication between its medical personnel and the particular attending physician.

ACTION: Adopted by House.

* * *

SAFETY BELTS

Resolution No. 3.
Author: Robert C. Combs.
Representing: San Francisco Medical Society.

WHEREAS, It is now known that the use of safety belts in automobiles effects a substantial reduction of death and injuries in crashes; and

WHEREAS, The number of persons currently killed or injured annually in automobile crashes is large enough to constitute a public health problem; now, therefore, be it

Resolved, That the House of Delegates of the C.M.A. urge the state legislature to make mandatory the installation and use of such belts in all new vehicles registered in California.

ACTION: Adopted by House.

(Comment by Reference Committee No. 3B: "The committee was made aware of the fact that the major automobile manufacturers are underwriting the costs of an investigation being performed by Cornell University into the problem of motor vehicle safety. The committee recognizes the broad aspects of this continuing problem which includes other safety devices such as recessed and padded dashboards, recessed steering columns and more secure door latches. The committee feels this is an excellent preliminary step in the direction toward highway safety . . .")

* * *

C.P.S. FEE SCHEDULE

Resolution No. 5.
Author: J. G. Middleton and J. Barry Smith.
Representing: San Luis Obispo County Medical Society.

WHEREAS, The C.P.S. fee schedule is recognized as a fee schedule acceptable to the members of the C.M.A. when in reality it is a substandard fee schedule; now, therefore, be it

Resolved, That this fee schedule be brought up to a realistic fee schedule.

ACTION: Adopted by House.

INDUSTRIAL ACCIDENT CASES

Resolution No. 6.
Author: J. G. Middleton and J. Barry Smith.
Representing: San Luis Obispo County Medical Society.

WHEREAS, Industrial accident cases represent people in a financially sound part of our economy and fees paid for such cases are substandard; now, therefore, be it

Resolved, That every effort be made to bring the fees up to a realistic level.

ACTION: Adopted by House.

* * *

PROTECTION OF THIRD PARTY INTERESTS

Resolution No. 9.
Author: Winston C. Hall.
Representing: San Diego County Medical Society.

WHEREAS, The continued interjection of a third party in the doctor-patient relationship is inevitable as long as prepaid health plans and government promoted programs continue to expand; and

WHEREAS, The third party must receive an assurance that a properly itemized bill will be furnished the patient and that any alleged abuses or questionable practices will not go unnoticed; now, therefore, be it

Resolved, That this House of Delegates of the California Medical Association instruct the Council of the California Medical Association to urge all county societies to offer where existent the use of review committees to all third party insurance carriers and government agencies so any unresolved disputes over medical services or fees may be heard: the purpose being to furnish authoritative information to enable third parties to take such action as is necessary to protect their rightful interest.

* * *

FEE SCHEDULES

Resolutions Nos. 14, 20, 26, 43 and 54.*
Author: C. E. Horn.
Representing: Sacramento County.

(Comment by Reference Committee No. 3: "Resolution No. 14 has to do with fee schedules; Resolution No. 20 has to do with a code of medical economics; the subject of No. 26 asks for a description of medical services and a dollar schedule of fees; No. 43 involves the principles of medical socio-economics and finally, No. 54, the Council resolution, involves the development of medical fees.

"It is the committee's opinion that all of these resolutions are concerned primarily with the development of principles of medical economics and have a common interest. It seems logical to this committee that all of these topics of necessity must be considered together. We therefore offer to you a substitute resolution.

"There has been an increasing clamor from the membership and the Council for a statement of policy, and in this substitute resolution we offer for the consideration of the House a solution to this complex problem.

"Within the context of this substitute resolution you will be referred to Resolutions No. 3 and No. 4 passed by this House of Delegates in 1954. I would like to read to you this action which was adopted.

"Resolution No. 3

***"RESOLVED,* That the California Medical Association proceed with vigor in the study, development and implementation of the Usual Fee Indemnity Plan.**

"Resolution No. 4

***"Whereas,* Many people are anxious to know in advance what their attending doctors' fees will be in order that they may secure adequate insurance or other means to pay those fees without worry about the financial problem at the time they need medical care; and**

***"Whereas,* Nearly all doctors already have fees which are their customary charges for the particular service involved; now, therefore, be it**

***"RESOLVED,* That the California Medical Association urge each of its members (a) to set up a list of his own fees, (b) to make this list known to his own patients, and (c) to assure his patients that he will make no higher charges except by agreement with the patient concerned before service is given.**

"It has come to the attention of the committee that many of the newer members of the House of Delegates may not be acquainted with the background of the Usual Fee Indemnity Plan. If it is the desire of the House, and you will so indicate, I shall be happy to ask the Speaker of the House for the privilege of the floor for a representative of Alameda-Contra Costa Medical Association. He will present a brief explanation of the Usual Fee Indemnity Plan which has been used successfully for the last five years in Alameda-Contra Costa County. This plan prompted the adoption of resolutions No. 3 and No. 4 of the 1954 House of Delegates.

"Mr. Speaker, I now present the committee's substitute resolution entitled 'Development of Principles of Medical Economics'."

WHEREAS, The ever increasing interposition of third parties between physicians and patients threatens the existence of the private practice of medicine; and

WHEREAS, In the private practice of medicine it is the responsibility of the patient to pay the physician's fee; and

WHEREAS, Schemes of nationalization hinder the development of voluntary prepaid health insurance; and

*Doctor Horn is shown as the author of the first resolution of this series on the same subject. As shown above, Reference Committee No. 3 combined these into one substitute resolution which was adopted by the House of Delegates.

WHEREAS, Medicine has heretofore participated in the development of prepayment health insurance; and

WHEREAS, There is a need for the C.M.A. to reestablish its position in relationship to the economic aspects of private medical practice; and

WHEREAS, The C.M.A. Council urgently desires further and definitive guidance from the C.M.A. membership; now, therefore, be it

Resolved: 1. That it be reaffirmed that each physician is privileged to charge a fair fee for his services.

2. That each physician is to be guided by fees charged within his county or economic area.

3. That it is the responsibility of the local county medical societies to review when indicated the fees charged by their members.

4. That C.P.S. is the agency of the C.M.A. through which fixed service contracts are established.

5. That the House of Delegates reaffirm its support of the Usual Fee concept incorporating the principle of prior agreement as outlined in Resolutions No. 3 and No. 4 adopted in 1954 by this House of Delegates.

6. That another survey be made in 1958 of the fees charged by C.M.A. members and that annual rechecking surveys be made thereafter.

7. That in any discussion of doctors' fees it is recommended the current Relative Value Studies be used as a base with a factor determined by an annual statistical survey.

8. That any consideration of fee schedules incorporate free choice of physicians and fee for service.

ACTION: Adopted by House.

* * *

ADVERTISING

Resolution No. 16.
Author: Dave Dozier.
Representing: Eleventh Councilor District.

Resolved, The House of Delegates of the C.M.A. commends the Committee on Advertising of CALIFORNIA MEDICINE for its excellent work. It feels certain that this good work will continue; and be it further

Resolved, That this House of Delegates instruct the Delegates of the C.M.A. to the A.M.A. to introduce resolutions in the American Medical Association House of Delegates calling the attention of other journals sponsored by medical associations to the rules for advertisers published by the advertising committee of CALIFORNIA MEDICINE in the hope that the general level of professional pharmaceutical advertising in current literature may benefit thereby.

ACTION: Adopted by House.

(Comment of Reference Committee No. 3B: "Committee 3B is entirely in accord with the intent of this resolution. A printed set of rules for the guidance of advertisers was submitted to the committee, which found that the present rules for advertising in *California Medicine* are very commendable. The advertising committee for *California Medicine* is composed of a representative of the Food and Drug Administration together with practicing physicians of unquestioned repute. . . . It was realized that rules are only as good as the men who apply them. Your reference committee is confident that the present advertising committee has been doing a superb job. Members are invited to compare advertising in *California Medicine* with that in other journals in the United States. The committee therefore recommends the substitute resolution . . ." shown above.)

* * *

C.M.A. DEPARTMENT OF NEGOTIATIONS

Resolutions Nos. 25, 30 and 64.*
Author: Albert E. Long.
Representing: San Francisco Medical Society.

WHEREAS, The American people have expressed a desire for protection against the cost of illness in all age brackets; and

WHEREAS, We in medicine wish to preserve the traditional relation between physician and patient and to minimize the interposition of three parties; and

WHEREAS, In 1957 the House of Delegates passed the following resolution: "That the Council of the C.M.A. develop a department with adequate staff whose duty it shall be to represent the organized medical profession in negotiations with representatives of any and all groups which are designed to provide or control the furnishing of medical care to private citizens in this state"; and

WHEREAS, The C.M.A. Council has had this under study and has not been able to formulate guides for the most effective manner of negotiations with third parties; now, therefore, be it

Resolved, That the C.M.A. Council be directed to expedite the creation of a department to operate within the C.M.A. structure. Inasmuch as this department's scope of activity is purely economic it is recommended that it be kept separate from the administrative structure of C.M.A.; and be it further

Resolved, That the immediate problem of this

*Resolutions No. 30 and No. 64, also introduced from San Francisco, were combined with No. 25 in the substitute resolution shown here.

department shall be a study of the feasibility and propriety of developing a separate foundation to represent physicians in the fields of socio-economic research, study and negotiations; and be it further

Resolved, That whenever state or federal law requires development of methods and fees for the care of individuals by private physicians, it shall be the duty of the Council of the C.M.A. or its authorized representatives to review and advise in the development of such contracts for physicians who choose to participate or whose patients must participate and award or withhold Council approval.

ACTION: Adopted by House.

* * *

C.P.S. SEPARATE PREMIUMS

Resolution No. 27.
Author: Robert C. Combs.
Representing: San Francisco Medical Society.

WHEREAS, In the formulation of contracts under C.P.S., it has been difficult for the patient to distinguish that portion of the premium which represents the services of physicians from all other services; now, therefore, be it

Resolved, That in all contracts under C.P.S. management, each C.P.S. member will receive communications enlightening him as to what premium represents solely and exclusively the cost of services rendered by the attending physician.

ACTION: Adopted by House.

* * *

BASIC MEDICAL RIGHTS OF AMERICAN CITIZENS

Resolution No. 28.
Author: Albert E. Long.
Representing: San Francisco Medical Society.

WHEREAS, In the social trend toward organized programs for the purpose of obtaining protection against the unexpected costs of illness, various governmental agencies now act as third parties for the purpose of organizing and managing such programs, thus interposing themselves between physicians and patients; and

WHEREAS, Certain of these plans have resulted in the surrender to bureaucratic control of the freedom of action of the individual; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association approve the following principles:

We, as physicians of California, cognizant that the American citizen enjoys certain basic rights as his heritage, and that these rights extend to the citizen in his position as a patient, do hereby specify these basic medical rights:

1. He shall have the right to retain the physician of his choice, at office, home or hospital, and shall be free to terminate the professional relationship at his pleasure.

2. He shall have the right to the special skills and techniques of medicine, and to the advantages of consultation. His physicians shall have qualifications which have been determined by their peers, not by legislation; no governmental action shall create, to his detriment, first, second and third class physicians with first, second, and third class abilities, training, duties, or remuneration.

3. He shall have the right to know that his physician is responsible for all decisions regarding the extent of his medical care, and that these decisions are not dictated, restricted, or suborned by any third party. Nor shall legislative action or executive edict force his physician to regard him as a chattel, a number, or a head. It shall be recognized that any person covered by such programs is not medically indigent.

4. He shall have the right to know that the management of his medical program is efficient and open to inspection.

This House of Delegates instructs the Council and its representatives to maintain these principles as the basis for participation in any program of medical care, and instructs the delegates of the California Medical Association to the A.M.A. to press for immediate affirmation of this resolution.

ACTION: Adopted by House.

* * *

RELATIVE VALUE STUDY IN C.P.S.—SCHEDULES A & B

Resolution No. 29.
Author: Don C. Musser.
Representing: San Francisco Medical Society.

WHEREAS, In the report of the Commission on Medical Services a meeting was held with the executive committee of the Commission and the Executive Committee of the Board of Trustees regarding the possibility of bringing the C.P.S. Schedules A and B up to a level which more closely approximates current fees throughout the state; and

WHEREAS, It was agreed that, consistent with good business practices, the C.P.S. Board of Trustees will develop ways and means of increasing income levels so that the relative value study on a $4.00 unit basis can be eventually (even though gradually) implemented on the present Schedule A; and

WHEREAS, It was also agreed that consistent with

good business practices, the C.P.S. Board of Trustees will develop ways and means of increasing income levels so that the relative value study on a $5.00 unit basis can be eventually implemented on the present Schedule B; now, therefore, be it

Resolved, That the C.P.S. be instructed to adopt and implement the Relative Value Study in Schedules A and B.

ACTION: Adopted by House.

(Comment by C.P.S. Reference Committee: "The committee feels that since a changeover of C.P.S. fees to comply with the Relative Value Study as mentioned in the body of this resolution as being a gradual process and because this changeover now is already being studied by the Council and the C.P.S. Board of Trustees, and realizing it may consume some time, the committee does not feel that C.P.S. should be restricted by placing a definite time limit . . .")

* * *

CONFIDENTIAL STATUS

Resolution No. 31.
Author: Charles P. Lebo.
Representing: San Francisco Medical Society.

WHEREAS, The evolution of medical practice in recent years has complicated the classic concept of the physician-patient relationship by the addition of and interposition of certain third parties such as insurance carriers, governmental agencies, and legal practitioners and institutions; and

WHEREAS, Considerable confusion exists in the minds of physicians (and lawyers) concerning the ethical and legal aspects of the privileged communication as applied to physicians; now, therefore, be it

Resolved, That the Commission on Professional Welfare of the California Medical Association be directed to undertake a complete study of all phases of the confidential nature of the physician-patient relationship and render a report of their findings and recommendations to the House of Delegates of the California Medical Association at its 1959 annual meeting.

ACTION: Adopted by House.

* * *

HEALTH INSURANCE

Resolution No. 32.
Author: John F. Murray.
Representing: Fresno County Medical Society.

WHEREAS, Health insurance is of general interest to the public; and

WHEREAS, State educational facilities, especially colleges and universities, present curricula dealing with health insurance; and

WHEREAS, Faculty members have been known to emphasize or recommend certain aspects and types of medical insurance rather than presenting all conflicting viewpoints on the subject; and

WHEREAS, Many doctors of medicine in the California Medical Association and component county societies have had extensive experience in health insurance which qualifies them as competent consultants; and

WHEREAS, Such tax-supported educational programs should democratically present all views; now, therefore, be it

Resolved, That the House of Delegates instruct the Council to present to the governing bodies of tax-supported institutions of learning, means of having the medical profession act as qualified consultants in curricula and extra-curricular programs in order to provide democratic views on such educational programs.

ACTION: Adopted by House.

* * *

REIMBURSING PRESIDENT, PRESIDENT-ELECT

Resolution No. 34.
Author: Donald M. Campbell.
Representing: San Francisco Medical Society.

WHEREAS, Many deserving, desirable and younger candidates are unable to accept the nomination of President-Elect or President of the C.M.A. because of limited means; now, therefore, be it

Resolved, That the Council be authorized to allot to the President-Elect and President during their year of office a sum of not more than ten thousand dollars or one hundred dollars a day in excess of ordinary expenses while on C.M.A. business.

ACTION: Adopted by House.

(Comment by Reference Committee No. 3B: "Discussions before the Reference Committee indicated that there was divided opinion upon this subject. Apparently the question does not lend itself to resolution other than by a vote of the House. The committee gained the impression that the resolution was well received by the Delegates and the committee itself is in favor of the resolution.")

* * *

TAX EXEMPTION FOR MEDICAL EXPENSE

Resolution No. 40.
Author: Lewis T. Bullock.
Representing: Los Angeles County Medical Association.

WHEREAS, The Federal Government allows an exemption on the income tax for medical expenses up to $10,000.00; and

WHEREAS, The State of California restricts exemptions on income tax for medical expenses to $2,500.00; and

WHEREAS, The person with very high medical expenses is the one who most needs complete exemption for his medical expenses on his income tax; now, therefore, be it

Resolved, That the Officers, Council and Legislative Committee of the California Medical Association be instructed to take all necessary action to induce the State of California to make exemptions from income tax for medical expenses in California the same as accepted by the Federal Government.

ACTION: Adopted by House.

* * *

WASHINGTON OFFICE OF A.M.A.

Resolutions Nos. 41 and 70.*
Author: Edward H. Crane.
Representing: Los Angeles County Medical Association.

Resolved, That the A.M.A. be asked to make an immediate reevaluation of the functions of the Washington office of the A.M.A. and to institute such changes and other modifications or new approaches as may be necessary to provide medicine with effective public and government relations.

ACTION: Adopted by House.

* * *

NATIONAL LIBRARY OF MEDICINE

Resolution No. 44.
Author: William F. Quinn.
Representing: Los Angeles County Medical Association.

WHEREAS, Funds will doubtless be provided by the Congress of the United States for construction of an appropriate building to house the National Library of Medicine; and

WHEREAS, Recent weather damage has made emergency repairs on the existing structure imperative; therefore, be it

Resolved, That the rich heritage of the National Library of Medicine be protected and maintained by giving this project the highest priority; and be it further

Resolved, That copies of this resolution be forwarded to the appropriate senatorial and congressional representatives from California.

ACTION: Adopted by House.

*Reference Committee combined these two resolutions into the substitute resolution shown above, which was adopted by the House of Delegates.

EMERGENCY FACILITIES AND THE PHYSICIAN

Resolution No. 45.
Author: Fordyce Johnson.
Representing: Los Angeles County Medical Association.

Resolved, That the Council of the California Medical Association continue to sponsor a widespread educational program among physicians and the public emphasizing the role of the personal physician in emergency as well as routine and preventive care and urging selection of such a physician before the need arises.

ACTION: Adopted by House.

(Comment by Reference Committee 3B: "For many years there has been an educational campaign among physicians and the public recommending the selection of a personal physician. This resolution amplifies the subject by placing emphasis on the desirability of such a relationship before the existence of an emergency.")

* * *

PATIENT RESPONSIBILITY IN MEDICAL CARE PLANS

Resolution No. 46.
Author: Paul Hoagland.
Representing: Los Angeles County Medical Association.

WHEREAS, Socio-economic changes in our society have resulted in increasing third party participation in the distribution and control of Medical Care; and

WHEREAS, Such third party participation may improve the distribution of Medical Care through the principles of pre-payment and insurance; and

WHEREAS, The serious danger in such third party participation is the threat of lowered standards of quality (due to interference with the feelings of personal responsibility of the physician for his patient, and the patient for sound and economical use of medical services); and

WHEREAS, Personal responsibility of both the physician and the patient are encouraged if the patient has a continuing financial interest in his medical care (through the use of deductibles, co-insurance, and policy restrictions controlling injudicious demand for medical services); now, therefore, be it

Resolved, That the California Medical Association adopt the policy that no future proposal for third party participation in the distribution of Medical Care (whether by government plans, medical service plans, insurance companies or other agencies) will receive unqualified endorsement unless such proposal contains adequate provisions for continuing patient financial participation in his medical services, as by the use of deductibles, co-insurance, and other reasonable restrictions.

ACTION: Adopted by House.

(Comment by Reference Committee 3B: "A number of health insurance policies embracing this principle have already been written, covering a great number of beneficiaries in industry. The principle of deductible insurance has been thoroughly understood and accepted in the automobile insurance field.")

* * *

TAX DEDUCTION FOR TUITION COSTS OF HIGHER EDUCATION

Resolution No. 47.
Author: William F. Quinn.
Representing: Los Angeles County Medical Association.

WHEREAS, Ever increasing federal and state taxes are becoming more burdensome to the average citizen; and

WHEREAS, The United States Government recognizes the need, necessity and requirement of higher education and training in the scientific and professional fields; and

WHEREAS, The tuition costs and fees of students maintained in state supported universities are less than tuition costs and fees of students in private supported universities due to subsidy by tax funds; and

WHEREAS, The tuition costs and fees of students maintained in private institutions of higher education are entitled to benefits and considerations equal to those of a student maintained in a subsidized state university; and

WHEREAS, The tuition expense and fees incurred by a student attending a private institution of higher education should be deductible to the taxpayer to offset and equalize the subsidy granted the student of a state supported university; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association urge the legislative committee of the American Medical Association and Members of Congress, from the State of California, and members of the State Legislature of the State of California, to take such steps to initiate or to have introduced into the Congress of the United States and the Legislature of the State of California, legislation which would have as its object as allowing all items incurred in the maintenance of a student in a recognized college or university for tuition or fees as a deductible item in the computation of gross income for federal and state income tax purposes.

ACTION: Adopted by House.

(Comment by Reference Committee No. 3B: "Reference Committee 3B considers that there is much merit to this suggestion . . .")

NURSE TRAINING PROGRAM

Resolutions Nos. 49, 50 and 51.*
Author: Robert Dennis.
Representing: Santa Clara County.

WHEREAS, It is fundamental that the medical profession and the public are deeply concerned with good, sound nursing care for the sick and injured, and thus believe in modern training programs for nurses assuring such care; and

WHEREAS, Many leaders in the field of nursing education have altered the nursing program of training so that future graduates of nursing will be poorly equipped for the care of their patients because of overemphasis on academic training and because of limited necessary practical experience; and

WHEREAS, It is believed that the medical profession at county, state, and national levels, could be of great assistance to the nursing profession, in planning programs of training which would be consistent with nurses' needs and dignity, while at the same time assuring physicians and the public of experienced and well-balanced nursing care; and

WHEREAS, Recent training programs have not utilized the recommendations of the medical profession; now, therefore, be it

Resolved, That the C.M.A. Council initiate continuing discussions with representatives of the California Nurses Association, California League of Nursing, the California Board of Nurse Examiners, the California Hospital Association, and all other interested groups, to resolve the inadequacies in quality and quantity of nurse training. The results of such discussions shall be disseminated to the medical profession through reports to the county medical societies and editorialized in CALIFORNIA MEDICINE; and, be it further

Resolved, That the Delegates to the A.M.A. be instructed to request similar conferences on the national level.

ACTION: Adopted by House.

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*Reference Committee 3B combined these three resolutions into a substitute resolution shown above. The committee commented that it was "appalled to learn that the advice of highly competent and esteemed physicians on advisory committees and the California State Board of Nursing had been ignored to such an extent that it frequently became difficult to enlist the services of competent physicians to serve in these capacities, which had now become such chores."

EMERGENCY AUTOMOBILE INSIGNIA

Resolution No. 52.
Author: Leon P. Fox.
Representing: Santa Clara County Delegation.

WHEREAS, The Medical Profession of California is finding it more difficult to reach patients who are in need of emergency care, because of an increasing traffic problem; and

WHEREAS, The safety of the physician during emergency travel is lacking under present conditions; and

WHEREAS, The traffic patrolmen, who are already very cooperative, should be able to identify the emergency physician immediately and should through enabling laws be permitted to allow him to pass conventional blocks and obstructions undetained; now, therefore, be it

Resolved, That the Council of the C.M.A. be directed to take necessary action to amend the California Motor Vehicle Code authorizing doctors of medicine to have special, standard, properly lighted, emergency signal markers on their automobiles, and that all police be directed to recognize them.

ACTION: Adopted by House.

(Comment by Reference Committee No. 3B: "With the increased density of population and traffic congestion the problem outlined in this resolution becomes more and more onerous. Resistance has been encountered, however, when similar insign'a have been desired in the past. This resolution calling for amendments to the California Motor Vehicle Code approaches the problem logically because uniform statewide adoption of the insignia must necessarily be by a legislative process which will declare physicians' cars as emergency vehicles and accurately delineate privileges conferred and penalties inflicted for their violation and abuse.")

* * *

FACULTY PRIVATE PRACTICE

Resolution No. 53.
Author: Clyde L. Boice and Burt L. Davis.
Representing: Santa Clara County Delegation.

WHEREAS, The Council of the C.M.A. appointed a Special Committee on the Private Practice of Medicine by Medical School Faculty Members in 1956; and

WHEREAS, The resolution recommending establishment of this committee requested yearly reports; and

WHEREAS, The 1957 report of this Special Committee was enthusiastically received by this House of Delegates; and

WHEREAS, The C.M.A., as an organization and through its individual member's efforts, has evidenced its interest in the welfare of California's Medical Schools; and

WHEREAS, We have not been informed of the attitudes of the various medical schools toward the recommendations contained in the Special Committee report; and

WHEREAS, As an organization and as individuals, we are interested in the attitudes of the medical schools; now, therefore, be it

Resolved, That the Special Committee on the Private Practice of Medicine by Medical School Faculty Members be instructed: (1) To meet with representatives of the medical schools and determine their attitudes toward this committee's report of 1957, and (2) annually to report its continuing findings to the House of Delegates.

ACTION: Adopted by House.

(Comment by Reference Committee 3B: "It has been quite apparent that a serious problem exists in the private practice of medicine by faculty members of medical schools or other physicians whose facilities are provided for them by tax-supported or by private institutions. The Council on Medical Services of the American Medical Association made a thorough study of the conditions and practices as they existed nationwide. The House of Delegates of the C.M.A. resolved in 1956 that such a study should be made by the California Medical Association. A special committee was appointed, chairmanned by Dr. Dwight Wilbur. The excellent report of this special committee was accepted by this House of Delegates in May of last year and became a basis of policy of the California Medical Association. Its urgency was emphasized by the fact that it was reproduced shortly thereafter in the July, 1957 issue of *California Medicine*. The response of medical administrators to the principles outlined in this report is of great interest to many physicians. Section III of the report states: 'The resolution referred to the Council by the Delegates last year (1956) requested that yearly reports be rendered by this committee. This, then, is our first report.'

"No second report has been forthcoming. The Reference Committee has been informed that this committee has held no further meetings. The adoption of this resolution, therefore, appears most timely.")

* * *

SOCIALISM

Resolution No. 58.
Author: Frederic P. Shidler.
Representing: San Mateo County Medical Society.

Be It Resolved, That the California Medical Association recognize government financed and administered medical plans as no different from governmental monopolistic operation of any industry; and be it further

Resolved, That the officers of the California Medical Association decline to bind its individual or

collective members to any agreement with a bargaining third party, and be it further

Resolved, That the California Medical Association assert its belief in democracy, warn its membership of the deeply entrenched position of power with which all forms of government surround its electorate, and declare its support of intellectual and economic freedom for all men, including physicians.

ACTION: Adopted by House.

* * *

CANCER QUACKERY LEGISLATION

Resolution No. 59.
Author: John W. Cline.
Representing: Cancer Commission.

WHEREAS, Legislation designed to combat cancer quackery and at the same time provide security for the freedom of research and the legitimate practice of medicine was introduced into the last session of the Legislature and received widespread support; and

WHEREAS, This matter was referred to a Senate Interim Committee for further study; and

WHEREAS, This Committee has held hearings, issued a progress report and will hold further hearings; now, therefore, be it

Resolved, That the California Medical Association express its appreciation and commendation to the Interim Committee for the fair, conscientious and thorough investigation in its undertaking; and be it further

Resolved, That the House of Delegates reiterate the opinion of the California Medical Association that legislation to curb cancer quackery is urgently needed; and be it further

Resolved, That the California Medical Association respectfully suggest to the Interim Committee that it give consideration to the following principles in the formulation of legislation.

1. A Cancer Council appointed by the Governor, composed in the main of physicians and surgeons and including members of the faculties of the schools and colleges in California granting degrees leading to licensure as physicians and surgeons in this state, be created within the Department of Public Health.

2. The Cancer Council should have the following responsibilities:

(a) To investigate and evaluate any drug, material, device or method used in or purported to be used in the diagnosis or treatment of cancer.

(b) To require that the Council be provided with samples of any drug, material or device in amount ample for investigation and all information pertinent thereto. Refusal to comply with a request of the Council to do so shall constitute a punishable infraction of law and in applicable instances shall constitute unprofessional conduct within the meaning of the Business and Professions Code.

(c) To hold hearings and to subpoena persons and documents for the purpose of its investigations.

(d) To make a finding of scientific fact as to the value or lack thereof concerning any method, drug, material or device used in the diagnosis or treatment of cancer.

(e) If after full and impartial hearing, any drug, material, or device be found to be harmful, lacking in value, fraudulent or deceitful to issue an order to cease and desist the use of such means or substantially similar means in the diagnosis or treatment of cancer which shall be binding upon the individual, group, body, association or organization using said means of diagnosis or treatment.

(f) To apply to the Superior Court of any county for the issuance of appropriate order restraining the use of said means of diagnosis or treatment of cancer.

ACTION: Adopted by House.

* * *

C.P.S. SPONSORSHIP OF *DOCTORS' NEWS CONFERENCE*

Resolution No. 61.
Author: John Schaupp.
Representing: San Francisco Medical Society.

WHEREAS, Members of the California Medical Association are desirous of giving the public an opportunity to see and hear accurate information concerning their health; and

WHEREAS, The TV program Doctors' News Conference, presented in the Bay Area through the cooperation of the San Francisco, San Mateo, Santa Clara, Marin and Alameda-Contra Costa Medical Societies, does disseminate beneficial and sound medical information; and

WHEREAS, California Physicians' Service will sponsor this program on Tuesday evenings at 8:00 p.m. for the next six months; and

WHEREAS, We have not been hesitant to criticize some actions of California Physicians' Service; now, therefore, be it

Resolved, That the California Medical Association go on record as commending California Physicians' Service for their cooperation with the physicians of California and their forward-looking attitude in sponsoring this public service program.

ACTION: Adopted by House.

FEES FOR PREPARATION OF INSURANCE FORMS

Resolution No. 62.
Author: James Thompson.
Representing: San Francisco Medical Society.

WHEREAS, The successful operation of both private and governmental health insurance plans requires the use of certain forms filled out and submitted to the respective carriers by physicians, and

WHEREAS, The preparation of these forms constitutes a medical service which occupies a significantly large and ever-increasing portion of the time of the physician and his office staff; and

WHEREAS, It is no longer economically possible to offer this medical service gratuitously; now, therefore, be it

Resolved, That the Commission on Medical Services of the California Medical Association be directed to include a section on fees for preparation of insurance forms in the Relative Value Fee Study and take whatever steps may be necessary to include fees for form preparation in the fee schedules of all insurance plans approved by the California Medical Association.

ACTION: Adopted by House.

NURSING PRACTICE ACT

Resolution No. 67.
Author: Edward Liston.
Representing: Santa Clara County Medical Society.

WHEREAS, Section 2718 of the Nursing Practice Act provides that the Board of Nurse Examiners shall appoint from a list of names presented by the C.M.A. the representatives who shall serve on the Advisory Council to the Board of Nurse Examiners; and

WHEREAS, This procedure enables the Board of Nurse Examiners to obtain only the advice it chooses to obtain; now, therefore, be it

Resolved, That the Legislative Committee of the California Medical Association take steps to amend the Nursing Practice Act to enable the medical profession to have a more effective voice in nursing education.

ACTION: Adopted by House.

DOCTOR-HOSPITAL RELATIONS

Resolution No. 71.
Author: Grant Ellis.
Representing: District 9 Delegation.

WHEREAS, The practice of radiology is a medical service and not a hospital service; and

WHEREAS, California law prohibits the practice of medicine by a corporation; and

WHEREAS, There exists at present an embarrassing inequity between radiologists who practice in hospitals under contracts of various kinds and radiologists who are in private practice of radiology; and

WHEREAS, The implementation of this resolution need not adversely affect revenue hospitals derive from the operation of x-ray departments; now, therefore, be it

Resolved, That the California Medical Association declare to all California hospitals having x-ray departments that radiologists who are members of the California Medical Association and who practice in hospitals shall practice as free and independent physicians with complete authority to conduct and supervise the operation of the x-ray department, and that the radiologist shall formulate all fees and if he desires shall submit and collect bills in his own name, and that there shall be no employer-employee relationship between hospitals and radiologists, and that radiologists' services be paid as medical services.

ACTION: Adopted by House.

RESOLUTIONS REFERRED TO COUNCIL

The following resolutions, by vote of the House of Delegates, were referred to the Council for further study and such action as the Council might wish to take. The Council will report back to the House of Delegates its decisions on the subjects involved.

INDIGENT CARE

Resolution No. 18.
Author: Eleventh C.M.A. District.
Representing: Eleventh C.M.A. District.

WHEREAS, Recent acts of the Congress of the United States and the Legislature of the State of California have brought on the people of the Nation and of this State an initial form of government controlled medicine which is bureaucratic, arbitrary and subject to governmental whim and mismanagement; and

WHEREAS, This is contrary to the best interests of the health of the elderly people of this State; and

WHEREAS, Politicians have further put in provisions which give nonindigent and nondeserving persons access to these medical services; and

WHEREAS, This is a further imposition on the taxpayers, statewide and nationwide; and

WHEREAS, These medical acts do indeed represent a relative failure of our public relations and legislative programs with the Legislature, Congress and the people at large; and

WHEREAS, Even more and greater abuses and inequities are apparent in the proposed Forand bill pending before the United States Congress; now, therefore, be it

Resolved: 1. That the House of Delegates instruct the Council of the California Medical Association to set up a specially designated committee to study, anticipate, educate, and, in the very best interests of the people of this State, prepare for similar legislation that will surely be presented in the not too distant future to our state lawmakers;

2. That this committee be empowered to engage the services of public relations experts and any others whose special aptitudes and qualifications might make their services of value;

3. That this House authorize this committee, subject to approval by the Council, to spend any reasonable sums to further this public relations and legislative program;

4. That should it become necessary, the Council be authorized to levy any assessments necessary to make this program successful; and be it further

Resolved, That this House of Delegates instruct the delegates to the American Medical Association to present resolutions similar to this in interest and purpose, at the coming session of the American Medical Association in San Francisco.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3: "This resolution contains a number of subjects, many of which are already in Council. Some of the subjects have already been disposed of by other resolutions . . . refer to the Council for further consideration.")

* * *

ESTABLISHMENT OF BETTER COMMUNICATIONS

Resolution No. 23.

Author: Charles D. Armstrong.

Representing and endorsed by San Mateo County Medical Society.

WHEREAS, There seems to be some dissatisfaction regarding the role of the California Medical Association Council in carrying out the wishes of California Medical Association members; now, therefore, be it

Resolved, That the California Medical Association appoint a properly constituted committee to accomplish the following functions:

1. Critically investigate the present system of representation in the California Medical Association and establish the validity of any complaints.

2. In the event valid deficiencies exist, recommend constitutional changes to correct them.

3. Suggest constitutional changes that clearly delineate the exact responsibility of the Council to act for the California Medical Association.

4. Consider use of opinion surveys on a county and state level, and, if appropriate recommend a mechanism to accomplish this.

5. Consider the institution of a system of monthly reports to the California Medical Association Council from constituent medical societies as a means of keeping the California Medical Association Council continuously posted on the views of the California Medical Association members.

6. Consider the institution of a system of monthly reports from the California Medical Association Council to constituent medical societies relative to Council activities and in particular, their proposed actions to keep the membership continually informed.

7. Report back to the House of Delegates, for approval, any other workable plan that the committee may devise to improve communications within the California Medical Association.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3B: "Communications in an organization approximating 16,000 physicians, many of whom find little time for political or economic considerations due to their great interest in the scientific aspects of the practice of medicine, are always very cumbersome. The C.M.A. Council, the various committees, both state and local, the county medical societies, and even hospital staff organizations have struggled with this problem which apparently continues to mount. Any suggestion which might help to relieve this situation should certainly be considered. Although this resolution contains a variety of suggestions, some of which might well be difficult to implement, your committee is of the opinion that these suggestions should be forwarded to the Council of the C.M.A.")

* * *

STUDY COMMITTEE—IMPACT OF SOCIALISM

Resolution No. 42.

Author: Peter Blong.

Representing: Los Angeles County Medical Association.

WHEREAS, Bureaucratic socialism has been on the march; and

WHEREAS, Medicine is now suffering from the same; now, therefore, be it

Resolved, That the California Medical Association implement a committee to study the impact of socialism on the practice of medicine, and to offer means of relief from the same.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3: "The committee feels that the resolution in implementing another committee will duplicate the work of an established committee.")

* * *

C.M.A. USE OF COUNTY SOCIETIES' PERSONNEL

Resolution No. 48.
Author: Anthony S. Felsovanyi.
Representing: Santa Clara County Medical Society.

WHEREAS, There is an evident and increasing need for experienced personnel to serve and assist the members of the various Commissions and Committees of C.M.A. in the pursuance of their objectives and obligations; and

WHEREAS, The need for such services and assistance is most often for part-time personnel with specific interests or experience rather than full-time personnel; and

WHEREAS, There are now 14 experienced and qualified full-time executive secretaries employed by component societies of the C.M.A., and 11 other persons serving 10 other societies in various capacities; now, therefore, be it

Resolved, That the House of Delegates encourage the C.M.A. Commissions to utilize the services of such persons and that the House of Delegates recommend that the Council of C.M.A. approve the use and part-time employment of such persons by C.M.A. Commissions and Committees; and be it further

Resolved, That reimbursement or compensation for such services be made to the respective county medical society or directly to the person so employed, on a basis that is mutually agreeable to the county society-employer of the person and the C.M.A.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3B: "Mr. John Hunton called attention of the committee to the fact that the county executive secretaries meet just prior to each C.M.A. Council meeting and are invited to be present at Council meetings at C.M.A. expense. This resolution suggests that the C.M.A. might gain much by use of the special knowledge and particular talents of this unique group. Details for the implementation of this plan might make it cumbersome in its execution.")

* * *

SPECIAL DIVISION OF THE A.M.A.

Resolution No. 63.
Author: A. Justin Williams.
Representing: San Francisco Medical Society.

WHEREAS, There continues to be increasing third party intervention, governmental and otherwise, between physician and patient to the detriment of good medical practice; and

WHEREAS, Third party intervention inevitably results in unnecessary and often arbitrary restrictions of medical practice and increased costs; now, therefore, be it

Resolved, That an entirely new special division of the American Medical Association be established and staffed with skilled, highly trained individuals responsible only to the A.M.A. Board of Trustees, and that the functions of this division should include

(a) To plan and execute a long range program of preserving the present system of medical practice and the rights of the individual physician to practice medicine in the manner of his choice.

(b) The formulation of further plans to meet the medical needs of the American people under the voluntary free enterprise system.

(c) To offer positive advice and assistance to state and local societies as to courses of action to follow as specific threats to voluntary medical care arise in their areas; and, be it further

Resolved, That the C.M.A. delegates to the A.M.A. introduce a similar resolution to the A.M.A. House of Delegates at the forthcoming meeting.

ACTION: Referred to Council.

(Comment by Reference Committee No. 3: "Because the content of this resolution involves the A.M.A. Board of Trustees, it is felt advisable that it be referred to the Council for further study and action.")

REFERRED TO COMMITTEE

One resolution, No. 60, was referred by the House of Delegates to the Committee on Claims Forms, a subcommittee of the Commission on Medical Services. This resolution reads as follows:

INSURANCE CLAIM PROCESSING

Resolution No. 60.
Author: F. J. Novak.
Representing: San Mateo County.

WHEREAS, Insurance claim processing in doctors' offices is an increasingly heavy burden; and

WHEREAS, Present claim processing is done by antiquated hand methods; therefore, be it

Resolved, That the California Medical Association appoint a committee to work out the possibility of having the many insurance companies pool their claims departments and form a central clearing house for claim processing. Such a clearing house should utilize the available electronic machines for less costly and speedier claim processing.

CONSTITUTIONAL AMENDMENTS ADOPTED

The Constitution of the California Medical Association was amended at the 1958 Annual Session when the House of Delegates by the required two-thirds vote adopted these amendments which had been lying on the table for one year and had been published in two separate issues of the official journal, as required by the Constitution.

As originally introduced, an additional amendment to apply to Section 14 of Article III, Part B, of the Constitution was included with the three amendments shown here. The House of Delegates voted against the proposed amendment to Section 14 and, instead, approved a By-Law amendment to provide a method of election of District Councilors.

As adopted by the House of Delegates, the amendments to the Constitution will make these sections read as follows:

AMENDMENTS

ARTICLE III

Part B—Council

Section 9—Composition

The Council shall consist of:

(a) Each Councilor District, as specified in this Constitution, shall be entitled to one Councilor for each 1,000 members, according to its membership as of the first day of November of the preceding year; provided that each Councilor District shall be entitled to a minimum of one Councilor.

(b) The President, President-Elect, Speaker and Vice-Speaker.

In addition, the Secretary-Treasurer, and Editor ex-officio, without the right to vote.

(c) District Councilors shall be elected from the Councilor Districts.

(d) Elected Councilors from any one District shall not, at any time, exceed forty per cent (40 per cent) of the total Council membership.

Section 10—Councilor Districts

There are ten districts as follows:

District Number One, comprising San Diego County.

District Number Two, comprising Imperial, Orange, Riverside, San Bernardino, Mono and Inyo Counties.

District Number Three, comprising the County of Los Angeles.

District Number Four, comprising Ventura, Santa Barbara and San Luis Obispo Counties.

District Number Five, comprising Kern, Kings, Tulare, Fresno, Madera, Mariposa, Merced, Stanislaus, San Joaquin, Calaveras and Tuolumne Counties.

District Number Six, comprising Monterey, San Benito, Santa Cruz, Santa Clara and San Mateo Counties.

District Number Seven, comprising San Francisco County.

District Number Eight, comprising Alameda County and Contra Costa County.

District Number Nine, comprising Marin, Solano, Napa, Sonoma, Lake, Mendocino, Humboldt and Del Norte Counties.

District Number Ten, comprising Sacramento, Amador, Alpine, Eldorado, Placer, Nevada, Sierra, Yuba, Sutter, Yolo, Colusa, Glenn, Butte, Plumas, Tehama, Trinity, Shasta, Lassen, Modoc and Siskiyou Counties.

Section 11—Election of Councilors

District Councilors shall be elected by vote of the delegates from each district in the manner and at the time specified in the by-laws; provided, however, that at the first meeting of the House of Delegates after a District Councilor has been selected, his name shall be submitted to the House by the delegates from the district, and (1) if there is no challenge by any delegate then the Speaker shall declare his election completed, and (2) if any delegate shall challenge the election on any ground, including fitness of the nominee of the district to serve as a District Councilor, the questions presented by the challenge shall be submitted to a Qualifications Committee consisting of the President, President-Elect and one delegate, appointed by the Speaker, from the Councilor District involved. The Qualifications Committee shall consider all grounds upon which the nominee is challenged and report back to the House. If the committee reports in favor of confirming the nominee's election, the Speaker shall declare him elected. If the committee reports against confirming the nominee's election, a three-fourths affirmative vote shall be necessary to sustain the report of the committee, in which event the nominee shall be ineligible to serve as the District Councilor and the delegates from the district shall immediately proceed to the selection of another nominee for the vacant office. If an adverse report of the Qualifications Committee is not sustained then the nominee shall be declared elected by the Speaker.

BY-LAW AMENDMENTS ADOPTED

The House of Delegates adopted a series of By-Law amendments at its 1958 Annual Session. Under the requirements of the By-Laws, all amendments must lie on the table for 24 hours before being acted upon. The amendments shown here were introduced at the first session of the House of Delegates on April 27, were referred to Reference Committee No. 4 and reported back, for vote, at the April 30 session.

By-Law amendments approved are shown here in the manner in which they were introduced and adopted. This presentation does not show the resultant wording of each section affected but defines the wording or paragraph in which a change was made.

Where parentheses and italics are used in the amendments shown, the words in parentheses have been deleted from the former By-Law section and the words in italics have been added.

Proposed amendments that were not adopted are not recorded in this abridged report.

* * *

REDUCTION OF DUES

By-Law Amendment No. 2.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter X, Section 3, of the By-Laws be amended so that paragraph (a) of that section be amended to delete the words shown here in parentheses and to add the words shown here in italics, so that this paragraph shall read as follows:

(a) Those active members who have been in the practice of medicine for less than (one) *three* years on the first day of the calendar year for which such dues were payable, may be reduced to (one-fourth regular dues) *such sum as the Council may recommend and the House of Delegates approve.*

And be it further

Resolved, That paragraph (b) and paragraph (c) of Chapter X, Section 3, of the By-Laws be deleted. And be it further

Resolved, That paragraph (d) of Chapter X, Section 3, be amended by deleting all language starting with the last syllable of the seventh line, relating to the dues of members who have reached the age of 70 years, and substituting therefor the following ". . . excused from the payment of annual dues."

* * *

AUDITING COMMITTEE

By-Law Amendment No. 3.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That the name of the Auditing Committee be changed to Finance Committee, and to accomplish that change, that Chapter VI, Section 7, of the By-Laws be reworded so that the term "Finance Committee" is substituted for the term "Auditing Committee" in the title and the text of the section; and be it further

Resolved, That Chapter X, Section 1, of the By-Laws be deleted in its present form and the following substituted:

CHAPTER X—FUNDS, PROPERTY, BUDGET AND ASSESSMENTS

Section 1—Preparation of Budget

The Finance Committee shall prepare each year a budget of anticipated income and expenditures, to apply to the succeeding fiscal year of the Association. The budget shall be prepared in consultation and with the cooperation of officers, commission and committee chairmen, administrative employees and others with a knowledge of the needs of the Association.

Prior to the Annual Session in each year the Finance Committee shall present the proposed budget to the Council for its approval, and the budget as approved by the Council shall be submitted by it to the House of Delegates.

And be it further

Resolved, That Chapter X, Section 6, of the By-Laws be amended as to the second paragraph of that section so that the words shown below in parentheses shall be deleted and the words shown in italics be inserted, so that the paragraph shall read as follows:

The (Auditing) *Finance* Committee shall inspect all bills and no demands or claims against the Association shall be paid and no funds or moneys of the Association be withdrawn from any depositary thereof except upon (written) approval of (a majority of all) the members of the (Auditing) *Finance* Committee on check or draft signed by (any two) persons authorized by the Council, providing all such authorized signers are under bond.

* * *

MEMBERSHIP COUNT

By-Law Amendment No. 4.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter IX, Section 2, Subsection (h), of the By-Laws be amended by deleting the words shown below in parentheses and inserting the words shown below in italics, so that the section shall read as follows:

(h) Register of Component Society, Their Mem-

bers and Officers. He shall keep a register of all component societies, their respective officers, and of all members of the Association, with their addresses. He shall print in the *December or* January (or February) issue of the official journal the number of active members of each component society as of (November) *September* 1st of the preceding year.

* * *

CHAIRMAN OF THE COUNCIL

By-Law Amendment No. 5.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter IX, Section 3, of the By-Laws be amended by adding the words shown below in italics, so that the section shall read as follows:

Section 3—Duties and Powers of the Chairman of the Council

The Chairman of the Council shall preside at all meetings of the Council. He shall *be authorized to* sign all contracts and agreements, conveyances, transfers and other instruments (other than advertising contracts) to which the Association is a party, the execution of which has been authorized by the Council or the House of Delegates. He shall *be authorized to* sign all checks or drafts. . . .

Balance of the section to remain in present language.

* * *

JUDICIAL COMMISSION

By-Law Amendment No. 6.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter III, Section 1, Subsection 6, of the By-Laws of the California Medical Association be amended as to the second paragraph of that section, so that the words shown in parentheses below shall be deleted and the words shown in italics shall be added:

(Either the Council or the Executive Committee) *The Judicial Commission* of the California Medical Association, whenever it shall come to (the) *its* attention (of either) that a disciplinary proceeding is pending before any component society, may . . .

Balance of the section to remain in present language.

And be it further

Resolved, That Chapter III, Section 1, Subsection 10, of the By-Laws be amended as to both paragraphs of that section by deleting the word "Council" and substituting therefore the words "Judicial Commission."

SECRETARY-TREASURER

By-Law Amendment No. 7.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Chapter IX, Section 2, of the By-Laws be amended to delete the word "-Treasurer" from the title of the section, so that the title refers to "Secretary" as one of the named persons.

And be it further

Resolved, That Chapter IX, Section 2(a), of the By-Laws be amended to delete the words shown here in parentheses, so that the subsection shall read:

(a) Minutes. The Secretary (-Treasurer, [who may also be referred to as Secretary or Treasurer]) shall attend the general meetings of the Association, the meetings of the House of Delegates *and* of the Council, (and of the Executive Committee) and shall keep minutes of their respective proceedings in separate record books.

And be it further

Resolved, That the title "Secretary-Treasurer" be amended to read "Secretary" in Chapter IX, Section 2, Subsections (a), (d), (e), (o), and (p); in Chapter II, Sections 2(a) and 2(b); in Chapter VI, Section 13; in Chapter VII, Section 10; in Chapter X, Section 6 and 7, and in any other chapter or section in which this title is now used as "Secretary-Treasurer."

* * *

EXECUTIVE COMMITTEE

By-Law Amendment No. 8.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That the Executive Committee be abolished and that a new committee to be known as the Advisory Committee for Emergency Action be established in its place; that, to accomplish this, Chapter VI, Section 6, of the By-Laws is hereby deleted in its entirety; and be it further

Resolved, That a new Chapter VI, Section 6, of the By-Laws is hereby adopted, to read as follows:

Section 6—Advisory Committee for Emergency Action

The Advisory Committee for Emergency Action shall consist of the President, the President-Elect, the Chairman of the Council and the Speaker of the House of Delegates.

It shall have no policy-making powers and shall function only under the direction of the Council. Its actions shall be subject to review and approval by the Council and it shall act only on matters requiring urgent decision while the Council is not in session.

And be it further

Resolved, That Chapter III, Section 1, Subsection 6, of the By-Laws be amended by deleting the phrase "or the Executive Committee" from the second paragraph of the section.

And be it further

Resolved, That the phrase "Executive Committee" or any reference to it or its chairman be deleted from Chapter VI, Section 10 and 15 and from Chapter IX, Section 2, Subsections (a), (i) and (r).

* * *

AMENDMENT TO BY-LAWS

By-Law Amendment No. 13.
Author: S. J. McClendon.
Representing: Constitution Study Committee.

Resolved, That Section 6 of Chapter VIII of the By-Laws of the California Medical Association be amended by changing the title of said section to read as follows: "Election of District Councilors in Districts Having One Councilor"; and be it further

Resolved, That a new Section 6.5 be added to Chapter VIII of said By-Laws to read as follows:

Section 6.5—Election of District Councilors in Districts Having More Than One Councilor

Immediately on the adoption of this section, and in succeeding years at least twenty-four hours prior to the second meeting at each annual session of the House of Delegates, the Delegates from those Districts in which more than one Councilor vacancy exists or is about to occur shall separately meet and in each such District the Delegates shall elect a chairman and a secretary.

At the first such caucus in each such District, the aggregate number of vacancies existing shall be divided into Offices No. 1, No. 2 et seq, with Offices Nos. 1, 4 and succeeding multiples of three carrying an initial term of one year and then thereafter terms of three years; with Offices Nos. 2, 5 and succeeding multiples of three carrying initial terms of two years and thereafter terms of three years; and with offices Nos. 3, 6 and succeeding multiples of three carrying initial terms of three years and thereafter terms of three years.

Nominations shall then be received for each individually numbered office in which a vacancy exists, and in each instance where there is more than one nomination, election shall be by secret ballot and majority vote of the Delegates present and voting. The chairman of the District delegation shall then report to the House of Delegates the results of the election, and when such report is made, the members elected shall thereupon assume office as District Councilors, subject to the provisions of the Constitution and By-Laws.

At the second and succeeding caucuses the Delegates in each such District shall by nomination, secret ballot and majority vote of the Delegates present and voting, elect District Councilors for each individual numbered District Councilor office from such District for which a vacancy is about to occur, and the chairman of the District delegation shall report at the second meeting of the House of Delegates the results of the election, and when such report is made, the member or members elected shall assume office as a District Councilor or District Councilors, subject to the provisions of the Constitution and By-Laws.

The time and place of the caucus of each District delegation shall, in the absence of unanimous written consent of the Delegates of the District fixing time and place, be fixed by the Speaker and announced at the first meeting of the House of Delegates at each annual session; except that on the adoption of this section, the Speaker shall immediately announce a time and place for the immediate caucus of each District that is at the time of said adoption, entitled to more than one District Councilor.

In the event there are more than two nominees at any District caucus for any of the individual numbered offices of District Councilor in said District and none of such nominees receives a majority of the votes cast on the first ballot, the nominee receiving the smallest number of votes on such ballot shall be eliminated and a second ballot shall be taken on the remaining nominees, such process to continue until one such nominee shall receive a majority of the votes cast.

* * *

JUDICIAL COMMISSION

By-Law Amendment No. 15.
Author: Donald A. Charnock.
Representing: Judicial Commission.

The Judicial Commission requests that Chapter III, Section 3 (paragraph 4) be changed to read:

"In every case of an appeal the Judicial Commission of this Association, through a committee thereof, prior to any hearing being held upon appeal may exert all proper efforts at conciliation and compromise."

* * *

AMENDMENT TO BY-LAWS—JUDICIAL COMMISSION

By-Law Amendment No. 16.
Author: John Blum.
Representing: District 9 Delegation.

WHEREAS, Chapter 3, Section 1, Paragraph 9, of the By-Laws of the California Medical Association

relative to disciplinary procedures limits the discretion of the Judicial Commission of the California Medical Association in providing that no member may be suspended for a period longer than one year; and

WHEREAS, When a member of the C.M.A. is suspended under this paragraph it is mandatory that he be reinstated into membership after the period of one year, regardless of his behavior during that period of suspension; now, therefore, be it

Resolved, That Chapter 3, Section 1, Paragraph 9, of the By-Laws of the California Medical Association be amended to delete the words "provided that in no case shall a member be suspended for a period greater than one year"; and be it further

Resolved, That this paragraph be further amended to add the words—"The Judicial Commission, at the end of the suspended member's period of suspension, may consider the quality of his behavior during his suspension in determining whether he shall be readmitted to the Society."

BY-LAW AMENDMENT OFFERED

One By-Law amendment was offered at the April session of the House of Delegates by Reference Committee No. 4, the committee to consider proposed amendments to the Constitution and By-Laws. Since all proposed amendments to the By-Laws are required to lie on the table for 24 hours before being acted upon, this amendment must await the next regular session of the House of Delegates before it can be voted upon. The proposed amendment to the By-Laws reads as follows:

AMENDMENT TO BY-LAWS

By-Law Amendment No. 1.
Author: J. B. Price.
Representing: Reference Committee No. 4.

Resolved, That Chapter VII, Section 1, of the By-Laws be amended as follows:

First, delete subsection (b) and insert

"(b) *Commission on Public Health,* responsible for the activities of and through which the following standing committees shall report:

1. Committee on Rural and Community Health,
2. Committee on School Health,
3. Committee on Mental Health,
4. Committee on Industrial Health.

"(c) *Commission on Public Agencies,* responsible for the activities of and through which the following standing committees shall report:

1. Committee on Military Affairs and Civil Defense,
2. Committee on State Medical Services,
3. Committee on Veterans Affairs,
4. Committee on Other Professions,
5. Committee on Blood Banks,
6. Committee on Allied Health Agencies.

Secondly, re-letter the following subsections from (c) to (d) through (1).

Except as herein amended, said Chapter VII, Section 1, shall remain unchanged.

CONSTITUTIONAL AMENDMENTS OFFERED

Four proposed amendments to the Constitution of the California Medical Association were presented at the 1958 House of Delegates. Under the terms of the Constitution, these proposed amendments must lie on the table for one year, or until the next regular session of the House of Delegates. Meanwhile, they must be published at least twice, in separate issues of the official journal.

All members of the Association, and especially the members of the House of Delegates, will thus have the opportunity to review these proposals during the coming year. They will be presented to the 1959 House of Delegates for vote, on which a two-thirds affirmative vote of those Delegates present and voting is required for passage.

* * *

SECRETARY-(TREASURER)

Constitutional Amendment No. 1.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Article VI, Section 1, of the Constitution be amended by deleting the term "-Treasurer" from the present term "Secretary-Treasurer" so that the named officer shall be known as "Secretary."

* * *

REPRESENTATION IN HOUSE OF DELEGATES

Constitutional Amendment No. 2.
Author: Sam J. McClendon.
Representing: Constitution Study Committee.

Resolved, That Article III, Part A, Section 2, of the Constitution of the California Medical Association be amended by deleting the words shown in parentheses below, so that the section shall read as follows:

Section 2—Representation

As the By-Laws shall provide, each component society shall be entitled to proportionate representation in the House of Delegates (but with a minimum of two delegates).

' ' '

REPRESENTATION ON THE COUNCIL

Constitutional Amendment No. 3.
Author: Sam J. McClendon.
Representing: Constitution Study Committee.

Resolved, That Article III, Part B, Section 9, of the Constitution be amended in subparagraph (a) by deleting the words shown in parentheses below and adding the words shown below in italics, so that subparagraph (a) shall read as follows:

(a) Each Councilor District, as specified in this Constitution, shall be entitled to one Councilor for each 1,000 *active* members, *or major fraction thereof,* according to its membership as of the first day of (November) *September* of the preceding year; provided that each Councilor District shall be entitled to a minimum of one Councilor.

' ' '

DELEGATES FROM SECTIONS

Constitutional Amendment No. 4.
Author: A. B. Sirbu.
Representing: San Francisco Medical Society.

WHEREAS, The scientific sections constitute an important part of the structure of the C.M.A.; and

WHEREAS, The sections are not represented in the legislative body of the C.M.A., the House of Delegates; and

WHEREAS, The sections of the A.M.A. have for many years been represented in its House of Delegates; and

WHEREAS, Each section of the C.M.A. has much to contribute toward policy making, both in the scientific and the economic phases of medicine; now, therefore, be it

Resolved, That each section of the C.M.A. be entitled to send one delegate with full voting rights to the House of Delegates of the C.M.A.; and be it further

Resolved, That the C.M.A. Constitution be amended to allow for such representation as follows: Article III, Section 1 amended by the addition of (e) Delegates elected by each scientific section as listed in Chapter IV, Section 1-a of the By-Laws.

' ' '

CONSIDERATION OF CONSTITUTIONAL AMENDMENTS

Constitutional Amendment No. 5
Author: W. S. Lawrence.
Representing: Butte-Glenn Medical Society.

WHEREAS, Any amendment to the Constitution should be for the greatest good of the Association; and

WHEREAS, The most recent amendment to the Constitution which eliminates the Councilors-at-Large was passed without prior hearings in the appropriate reference committee during any regular session of the Association; and

WHEREAS, This action has denied interested delegates the opportunity to meet, exchange views, discuss the ramifications and evaluate the appropriateness of the Amendment to meet its purpose; and

WHEREAS, The proponents of the amendment would be the last to feel the necessity to press such an action through the House of Delegates without adequate consideration; now, therefore, without prejudice to the previous amendment, be it

Resolved: That Article VIII, Section 3, Paragraph 2 of the Constitution be amended by addition of the following:

"Further, such proposed amendment or amendments shall be referred to the appropriate Reference Committee who shall hold hearings on the proposed amendment or amendments during the course of its regular business while the Association is in convention. If the proposal or proposals are introduced during the first session of the House, hearings shall be held at both the current and the next regular meeting. If the proposal or proposals are introduced during the second session, hearings shall be held at the next meeting, and in either event, prior to submission to the House of Delegates for vote.

ELECTION RESULTS

Elections held by the House of Delegates in its final session April 30 saw Doctor T. Eric Reynolds of Oakland elected as President-Elect of the California Medical Association for 1958-1959.

Doctor James C. Doyle was reelected Speaker of the House of Delegates and Doctor Ivan C. Heron was chosen as Vice-Speaker.

In the election of Councilors, who are selected by their own District Delegations, Doctors James C. MacLaggan of San Diego and Warren L. Bostick of San Rafael were chosen by their districts to serve additional three-year terms as Councilors and Doctor Burt L. Davis of Palo Alto was named by his district for a new three-year term.

Los Angeles County, entitled to six District Councilors under the terms of the revised Constitution,

chose Doctors Malcolm Todd of Long Beach and Arthur A. Kirchner of Los Angeles to serve one-year terms, Doctors Paul D. Foster of Los Angeles and Joseph P. O'Connor of Pasadena for two-year terms and Doctors J. Norman O'Neill of Los Angeles and Gerald W. Shaw of Santa Monica for three-year terms.

In selecting Delegates to the A.M.A. the House of Delegates reelected Doctors Leopold H. Fraser, E. Vincent Askey, Dwight L. Wilbur, Donald Cass, J. Lafe Ludwig, R. Stanley Kneeshaw, C. J. Attwood and James E. Feldmayer for additional two-year terms. The House also elected Doctor Donald A. Charnock a Delegate, to fill the new office created by the Association's membership growth.

As Alternate Delegates, incumbents Hartzell H. Ray, Francis J. Cox, J. Norman O'Neill, H. M. Van Dyke, Burt Davis, Arlo A. Morrison were all reelected for two-year terms. Doctor Ralph C. Teall was chosen as Alternate to succeed Edward C. Rosenow, Jr., and James C. Doyle was picked to fill the unexpired term of Donald A. Charnock for the balance of 1958 and for an additional two-year term. As the new Alternate the House picked Doctor Carl M. Hadley of San Bernardino.

Upon nomination by the Council, the House of Delegates reelected Doctors Dave F. Dozier and Arlo A. Morrison, Mr. Thomas Hadfield and Rt. Rev. Msgr. Thomas J. O'Dwyer as members of the Board of Trustees of California Physicians' Service. Also nominated by the Council and approved by the House was Doctor Paul Hoagland of Pasadena, to fill an unexpired term of office.

In accordance with the By-Laws of C.P.S. the Council also selected from its own membership Doctors Ivan C. Heron, Gerald W. Shaw and Burt L. Davis as Trustees of C.P.S. for the coming year.

* * *

In its own elections and appointments, the Council at an organization meeting held April 30 reelected Doctor Donald D. Lum as Chairman of the Council and chose Doctor Samuel R. Sherman as Vice-Chairman. Doctor Albert C. Daniels was reappointed Secretary and Doctor Dwight L. Wilbur was renamed Editor. Mr. John Hunton was reappointed Executive Secretary and the firm of Peart, Baraty & Hassard was reappointed as legal counsel.

In Memoriam

ATLAS, LAWRENCE N. Died May 22, 1958, aged 52. Graduate of Western Reserve University School of Medicine, Cleveland, Ohio, 1930. Licensed in California in 1952. Doctor Atlas was a member of the Los Angeles County Medical Association.

✤

BERGMAN, GEORGE CLYDE. Died December 21, 1957, aged 60. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1924. Licensed in California in 1924. Doctor Bergman was a member of the Los Angeles County Medical Association.

✤

CHADWICK, GLENN WILLIAM. Died March 12, 1958, aged 34. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1951. Licensed in California in 1951. Doctor Chadwick was a member of the Los Angeles County Medical Association.

✤

GUINAN, EDWARD ROBERT. Died in Palo Alto, May 26, 1958, aged 69, of congestive heart failure, pneumonia, and bronchogenic carcinoma. Graduate of Cooper Medical College, San Francisco, 1911. Licensed in California in 1911. Doctor Guinan was a retired member of the Alameda-Contra Costa Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

HERMAN, BORIS S. Died in San Francisco, May 8, 1958, aged 68. Graduate of the College of Physicians and Surgeons of San Francisco, 1919. Licensed in California in 1919. Doctor Herman was a member of the San Francisco Medical Society.

✤

KERR, WILLIAM J., JR. Died in Marin County, May 27, 1958, aged 39. Graduate of Harvard Medical School, Boston, Massachusetts, 1944. Licensed in California in 1946. Doctor Kerr was a member of the Marin County Medical Society.

✤

PARKER, CARL HORACE. Died in Pasadena, May 15, 1958, aged 75. Graduate of Rush Medical College, Chicago, Illinois, 1909. Licensed in California in 1909. Doctor Parker was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

SCHEPPLER, GEORGE CAROL. Died April 18, 1958, aged 41, of injuries received in an automobile collision. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1945. Licensed in California in 1945. Doctor Scheppler was a member of the Humboldt County Medical Society.

✤

SCHWING, HAROLD EDWARD. Died in Sacramento, May 18, 1958, aged 64. Graduate of the University of Buffalo School of Medicine, New York, 1923. Licensed in California in 1930. Doctor Schwing was a member of the Sacramento Society for Medical Improvement.